98TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 98-236
1st Session } { Part 2

HEALTH CARE FOR THE UNEMPLOYED ACT OF 1983

JUNE 30, 1983.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

together with

DISSENTING VIEWS

[To accompany H.R. 3021]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3021) to amend the Social Security Act to provide for a program of grants to States to provide health care benefits for the unemployed, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert in lieu thereof the following:

That this Act may be cited as the "Health Care for the Unemployed Act of 1983".

TITLE I—AMENDMENTS TO THE SOCIAL SECURITY ACT

NEW TITLE XXI (HEALTH CARE FOR THE UNEMPLOYED)

SEC. 101. (a) The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—HEALTH CARE FOR THE UNEMPLOYED

"PART A—BLOCK GRANTS TO STATES

"APPROPRIATION AND DEFINITIONS

"SEC. 2101. (a) For the purpose of enabling each State to furnish necessary medical benefits for unemployed individuals and their immediate family members, there is hereby authorized to be appropriated for fiscal years 1983, 1984, and 1985 a sum sufficient to carry out the purposes of this part. The sums made

available under this section shall be used for making payments to States under allotments under section 2102 for the development and operation of plans of medical benefits for the unemployed.

"(b) As used in this part—

"(1) The term 'group health plan' has the meaning given such term in section 162(i)(2) of the Internal Revenue Code of 1954.

"(2) The term 'immediate family member' means, with respect to an individual—

"(A) in the case of a married individual, the individual's spouse, and

"(B) the individual's child, if the child is under 18 years of age.

"(3) The term 'medical benefits' means payment of part or all of the cost of the care and services described in paragraphs (1), (2), (3), (4)(C), (5), (9), and (17) of section 1905(a) (subject to subdivisions (A) and (B) thereof) and of prescribed drugs.

"(4) The term 'number of weeks of regular unemployment compensation' means, for a State for a period, the sum, for each of the weeks in the period, of the number of individuals receiving regular compensation in that week under the State's unemployment compensation.

"(5) The term 'regular compensation' has the meaning given such term in section 205(2) of the Federal-State Extended Unemployment Compensation Act of 1970.

"(6) The term 'State' includes only the fifty States and the District of Columbia.

"(7) The term 'unemployment compensation' means cash benefits payable to individuals with respect to their unemployment (A) under any State unemployment compensation law, (B) under any Federal unemployment compensation law administered by a State, or (C) under the Railroad Unemployment Insurance Act.

"ALLOTMENTS AND PAYMENTS TO STATES

"SEC. 2102. (a) There shall be available for allotments for block grants to States under this part—

"(1) $350,000,000 for fiscal year 1983,

"(2) $1,869,000,000 for fiscal year 1984, and

"(3) $1,538,000,000 for fiscal year 1985.

"(b)(1) Subject to subsection (c), the Secretary shall allot the amounts available for allotments for each fiscal year under subsection (a) among States as follows:

"(A) One-third of the amount shall be allotted among the States on the basis of the relative number of unemployed individuals in the State during the applicable period compared to the number of such unemployed individuals in all the States during such period.

"(B) One-third of the amount shall be allotted among the States on the basis of the relative number of individuals in the State who exhausted regular compensation during the applicable period compared to the number of such individuals in all the States who exhausted regular compensation during such period.

"(C) One-third of the amount shall be allotted among the States on the basis of the number of weeks of regular unemployment compensation in the State during the applicable period compared to the number of weeks of regular unemployment compensation in all the States during such period.

"(2)(A) As used in subparagraphs (A) and (C) of paragraph (1), the term 'applicable period' means—

"(i) for allotments for fiscal years 1983 and 1984, the three-month period beginning February 1983, and

"(ii) for allotments for fiscal year 1985, the three-month period beginning February 1984.

"(B) As used in subparagraph (B) of paragraph (1), the term 'applicable period' means—

"(i) for allotments for fiscal years 1983 and 1984, the period beginning May 1982 and ending April 1983, and

"(ii) for allotments for fiscal year 1985, the period beginning May 1983 and ending April 1984.

"(3) Determinations under subparagraph (A) of paragraph (1) shall be based on data of the Bureau of Labor Statistics and determinations under sub-

paragraphs (B) and (C) of paragraph (1) shall be based on data of the Secretary of Labor.

"(c)(1) A State's allotment for fiscal year 1983 or 1984 may be carried forward and used for expenditures made under the State's plan in the following fiscal year if the State's plan remains in effect in that following fiscal year.

"(2)(A) If the chief executive officer of a State has not transmitted to the Secretary by September 15, 1983, a notice on behalf of the State of the State's intent to establish and have in effect in the State, not later than June 30, 1984, a plan under this part, the State's allotment for 1983 shall be reduced to zero.

"(B)(i) If the chief executive officer of a State has not transmitted to the Secretary by December 15, 1983, a notice on behalf of the State of the State's intent to establish and have in effect in the State, not later than June 30, 1984, a plan under this part, the State's allotment for 1984 shall be reduced to zero.

"(ii) A State's allotment for fiscal year 1984 shall be reduced by one-quarter for each calendar quarter (after the first calendar quarter) in which the State does not have a plan approved and in effect under this part and shall be reduced to zero if the State does not have such a plan approved and in effect by June 30, 1984.

"(C) A State's allotment for fiscal year 1985 shall be reduced to zero if the State does not have a plan approved and in effect under this part by June 30, 1984.

"(D) If a State has not submitted a report on its activities under its plan in accordance with section 2105(a) by February 1, 1985, the State's allotment for fiscal year 1985 shall be reduced by one-quarter.

"(3) To the extent that the total amount available for allotments under this part for a fiscal year is not otherwise allotted to States due to a reduction under paragraph (2) or because some States have indicated in their reports to the Secretary under section 2103(a)(6) that they do not intend to use the full amount of such allotments (including any reallotment under this paragraph) or to carry forward excess amounts under paragraph (1), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

"(d)(1)(A) From the sums appropriated therefor and the allotments available under this section and subject to the succeeding paragraphs of this subsection, the Secretary shall make payments as provided by section 6503 of title 31, United States Code, to each State from its allotment.

"(B) Any amount paid to a State for fiscal year 1983 or 1984 and remaining unobligated at the end of such year shall remain available to such State for obligation in the succeeding fiscal year if the State has in effect a plan under this part during that succeeding fiscal year.

"(2)(A) Except as provided in subparagraph (B), the Secretary may not make payments to a State under paragraph (1) for a fiscal year unless—

"(i) the State has a plan approved and in effect under this part,

"(ii) the State has made assurances satisfactory to the Secretary that the State will provide for any State contribution required under section 2103(f) towards expenditures under the plan for that fiscal year, and

"(iii) the State has provided for (or made arrangements satisfactory to the Secretary for the provision of) any such State contribution for any previous fiscal year.

"(B) With respect to payments from the allotment for fiscal year 1983, the Secretary may make payment to a State without a plan under this part, except that such payment may not exceed 10 percent of the State's allotment for that year and may only be paid for expenses incurred in the planning and development of such a plan.

"(3) The Secretary shall provide for such reconciliations (not less frequently than annually) of the amount of the payments made to States as may be necessary to insure that such payments are only used in accordance with this part and that States contribute the required share towards expenditures under the plans under this part. Amounts improperly paid shall be treated as overpayments, and the Secretary may offset such amounts from subsequent allotments under this part or may otherwise recover such amounts.

"(4) As a condition of payment to the State under this part, the State must provide assurances satisfactory to the Secretary that each group health plan offered by the State, by any political subdivision thereof, or by any agency or instrumentality of the State or a political subdivision thereof, meets the requirements of part B as they would apply if section 2125(1)(A) did not apply with respect to that State, subdivision, agency, or instrumentality. If the

Secretary, after reasonable notice and opportunity for a hearing to a State, finds that it or any of its political subdivisions, or any agency or instrumentality of the State or its political subdivisions, has failed to comply with the previous sentence, the Secretary shall terminate payments to such State under this part and notify the chief executive officer of such State that further payments under this part will not be made to the State until the Secretary is satisfied that there will no longer be any such failure to comply.

"STATE PLANS FOR MEDICAL BENEFITS FOR THE UNEMPLOYED

"SEC. 2103. (a) IN GENERAL.—Except as provided in section 2104, a State plan for medical benefits for the unemployed must—

"(1) provide for making medical benefits (as defined in section 2101 (b) (3) available to eligible individuals voluntarily enrolled under the plan for services consistent with subsection (c) ;

"(2) provide for making medical benefits available for such amount, duration, and scope of service (within those described in section 2101(b) (3)) as the State plan may specify consistent with subsection (d) ;

"(3) provide for the imposition of premiums, enrollment fees, and similar charges, and for deductions, cost sharing, and similar charges only in accordance with subsection (e) ;

"(4) provide for financial participation by the State in a manner consistent with subsection (f) ;

"(5) provide for administration of the plan and expenditures under the plan in accordance with subsection (g) ;

"(6) provide for reports and audits and nondiscriminatory practices in accordance with section 2105 and for periodic reports to the Secretary on the portions of the allotment to the State for each fiscal year which the State intends to use and the portions of such allotment which may be reallotted among the other States under section 2102(c) (3) ;

"(7) provide that—

"(A) the amount of payment to persons providing services covered under the plan may not exceed the amount of such payment that is provided for such services under the State's plan under title XIX, and

"(B) each such person must agree to comply with the conditions of subsection (e) respecting limitations on the charges that may be imposed on beneficiaries for receipt of covered services (and the provisions of section 1916(c) shall apply to such providers in the same manner as they apply to providers under a State plan under title XIX) ;

"(8) provide that the plan—

"(A) shall be secondary in payment to any insurance or benefit plan (including a group health plan, the insurance program or a State plan under titles XVIII and XIX of this Act, an automobile or liability insurance plan, and no fault insurance) which provides medical benefits, and

"(B) shall require each individual enrolled in the plan, as a condition of enrolling in the plan, to assign to the State all rights to payments, under a plan described in subparagraph (A), to which the individual may be entitled ;

"(9) provide that in the case of an individual enrolling for benefits under the plan who is not receiving unemployment compensation, the State will take reasonable steps to determine the eligibility under section 1902(a) (10) (A) of the individual for assistance under the State plan approved under title XIX : and

"(10) meet the requirements specified in paragraphs (1), (3), (7), (8), (9), (22)(B), (22)(D), (23), (27), (33)(A), and (33)(B) of section 1902 (a) in the same manner as such requirements apply to State plans under title XIX.

"(b) APPROVAL AND DISAPPROVAL OF PLANS.—(1) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes as a condition for eligibility for medical benefits under the plan any citizenship requirement which excludes any citizen of the United States or any residence requirement which excludes any individual who resides in the State.

"(2) The Secretary shall disapprove, or withdraw the approval of, any plan of a State under this part if the Secretary determines that—

"(A) the State provided for eligibility, under its plan under section 402 as of June 1, 1983, of dependent children described in section 407 (relating to dependent children of unemployed parents) and, after such date, discontinues coverage of such children under such plan;

"(B) the State provided for eligibility, under its plan under title XIX as of June 1, 1983, of individuals who are receiving, are eligible to receive, or could be eligible to receive (if coverage under its plan under title IV was as broad as allowed under Federal law) aid pursuant to the operation of section 407 (relating to dependent children of unemployed parents) or who are described in section 1905(a)(i) (but not in section 1902(a)(10)(A)(i)), and, after such date, discontinues or reduces the terms of eligibility of such individuals under such plan; or

"(C) the State has made other significant reductions in eligibility or benefits under its plan under title XIX in order to establish or operate a plan under this part.

"(3) Nothing in this section shall be construed as preventing a State from terminating its plan under this part and establishing a date after which the State is no longer obligated for expenses for medical benefits incurred under the plan.

"(4) Sections 1116 and 1904 shall apply to plans approved under this part in the same manner as they apply to plans approved under title XIX, except that any reference to the provisions of section 1902 or 1904 in those sections shall be deemed for this purpose to be a reference to the provisions of this section or this paragraph, respectively.

"(c) ELIGIBILITY FOR MEDICAL BENEFITS.—(1) Each State plan shall specify the criteria (consistent with this subsection) for determining those individuals who are eligible for medical benefits under the plan, which criteria shall be applied uniformly. Each individual who meets such criteria shall be eligible to enroll for medical benefits under the plan.

"(2) Except as provided in paragraphs (3) and (4), an individual may not be eligible for medical benefits under a State plan unless the individual is unemployed and—

"(A) is receiving unemployment compensation or received unemployment compensation for a week in the previous 104-week period, or

"(B) subject to paragraph (5)—

"(i) has been previously employed (as determined under the plan), and

"(ii) meets such reasonable financial or medical needs standards as the State plan specifies.

The State plan shall provide for standards respecting the circumstances under which an individual is considered 'employed' and 'unemployed' for purposes of the plan and the State plan may not make, as a condition of eligibility of any individual under subparagraph (A), any determination respecting the income or assets of any individual.

"(3)(A) Except as provided in paragraph (4), for any period in which an individual is entitled to medical benefits under the plan, the individual's immediate family members (as defined in section 2101(b)(2)) also shall be entitled to medical benefits under the plan.

"(B) In the case of an individual who is eligible and enrolled for medical benefits under a State plan, the plan may continue the individual's eligibility during a period (of not longer than four weeks) specified in the State plan during which the individual is reemployed.

"(4)(A) Except as provided in subparagraph (B), the State plan shall specify the uniform minimum length of time an individual must have been previously unemployed in order to be eligible for medical benefits under paragraph (2)(A).

"(B)(i) Subject to clause (ii), a State plan may provide for a minimum length of period of unemployment which is less than that specified in subparagraph (A), but only with respect to providing eligibility for pregnant women, children under five years of age at the time of initial eligibility under the plan, and, at the State's option, immediate family members of such individuals.

"(ii) A State plan may provide for a period under clause (i) of—

"(I) less than one year (but greater than six months), only if the period described in subparagraph (A) is no greater than one year, or

"(II) less than six months, only if the period described in subparagraph (A) is no greater than six months.

"(5) A State plan must be reasonably designed so as to provide an amount of medical benefits in any fiscal year to individuals made eligible under paragraph (2)(B) (and their immediate family members) which is not less than 5 percent of the amount of the Federal payments to the State under section 2102(d) for that year and is not greater than the sum of—

"(A) 5 percent of the amount of the Federal payments to the State under section 2102(d) for that year, and

"(B) the amount (if any) by which the total amount of the expenditures under the plan for the year exceeds the sum of (i) the amount of the Federal payments to the State under section 2102(d) for that year and (ii) the amount of premiums collected under the plan for the year.

"(6) A State plan may not permit an individual to be eligible for medical benefits under paragraph (2) for a week if the individual—

"(A) is covered (or could have been covered, if an election had been made and any premiums required paid on a timely basis) for the week under a group health plan for which a contribution towards the cost of the plan is being made by an employer, union, or entity other than the individual or the individual's spouse;

"(B) is (or could be, if an enrollment after the date of the enactment of this part had been made and any premiums required paid on a timely basis after the individual became unemployed) covered for the week under a group health plan for the individual's spouse for which a contribution towards the cost of the plan is being made by an employer, union, or entity other than the individual or the individual's spouse; or

"(C) is determined to be eligible for the week for assistance under the State plan under title XIX.

"(7) If a State changes the criteria for eligibility of individuals under the plan, such changes must be made public and made in a manner consistent with the State administrative procedures act or other applicable State law. A State may provide that in the case of such a change that would have the effect of disqualifying individuals who are eligible and enrolled for medical benefits under the plan, the State may provide for continuation of eligibility of the individuals for a reasonable period of time or based on such reasonable standards as the State may establish, but not beyond the period of time which they would otherwise have remained eligible.

"(8) The State plan may limit the coverage period of eligible individuals under the plan to a period specified in the plan, but such period may not be less than one year in the case of individuals eligible under paragraph (2)(A).

"(9) A State plan must permit an eligible individual to terminate voluntarily enrollment under the plan by written notice to the State.

"(*d*) MEDICAL BENEFITS.—(1) A State plan must provide medical benefits for—

"(A) prenatal, delivery, post-partum, and well-baby care, without limitations of amount, duration, or scope except as to medical necessity;

"(B) at least the first day of inpatient hospital care in the coverage period for each eligible individual; and

"(C) at least some ambulatory services.

"(2) The scope, amount, and duration of medical benefits provided under the plan must be the same for all individuals eligible for medical benefits under the plan, except that the coverage period of individuals eligible under subsection (c)(2)(A) may differ from the coverage period for individuals eligible under subsection (c)(2)(B).

"(3) A State plan may not provide for medical benefits for expenses incurred for services furnished before the date the plan first becomes effective or after October 1, 1985.

"(e) PREMIUMS AND COPAYMENTS.—(1)(A) A State plan may impose a weekly premium for an individual who is eligible under subsection (c)(2)(A), is receiving unemployment compensation, and is voluntarily enrolled in the plan in an amount equal to not more than 5 percent of the amount of the unemployment compensation, if any, which is payable to the enrollee for the week (determined without regard to any deductions or offsets actually taken thereon). The State may provide for the deduction of the amount of such a premium from the amount of such compensation paid to the enrollee.

"(B) A State plan may impose a premium for an individual who is eligible under subsection (c)(2)(A), is not receiving unemployment compensation, and is voluntarily enrolled in the plan in an amount equal to not more than 2 per-

cent (or, if less, the percentage applicable under subparagraph (A) to individuals described in that paragraph) of the average monthly benefit amount in the State for unemployment compensation under State law (based on the most recent data available).

"(C) A State plan may not impose any premium, enrollment fee, or similar charge except as provided in this paragraph. If a State plan imposes a premium upon the enrollment of an eligible individual under the plan, the plan may not deem or otherwise treat the individual as being enrolled without the individual voluntarily enrolling under the plan.

"(D)(i) Except as provided under clause (ii), the applicable perecntage selected under subparagraph (A) or subparagraph (B) shall be uniform within the groups of individuals described in each of such subparagraphs.

"(ii) A State plan may provide standards whereby the premiums otherwise established under the plan are waived in the case of financial hardship or other good cause established by the State.

"(E) Premiums collected under a State plan must be used for the purpose of carrying out the plan and may be used, to the extent permitted under subsection (f)(4)(B), toward the State contribution for expenditures under the plan.

"(2)(A) A State plan under this part shall provide for the imposition, to the extent permitted under paragraphs (2) and (3) of section 1916 with respect to individuals eligible for medical assistance under State plans under title XIX, of—

"(i) a deductible, for the first day of inpatient hospital services furnished to an individual under the plan under this part, in an amount equal to at least 10 percent of the estimated average payment in the previous year for a day of inpatient hospital services under the State's plan under title XIX, and

"(ii) deductions, cost sharing, and similar charges for other services in the maximum amounts permitted pursuant to such paragraphs for such individuals for such services.

"(B)(i) Except as provided under clause (ii), the deductions, cost sharing, and any similar charges imposed under this paragraph shall be imposed uniformly for all individuals eligible for medical benefits under the plan.

'(ii) A State plan may provide standards whereby the deductions, cost sharing, and any similar charges imposed under this paragraph are waived in the case of financial hardship or other good cause established by the State.

"(f) STATE CONTRIBUTIONS.—(1) The State plan must provide for a State contribution towards expenditures under the plan in accordance with this subsection.

"(2) With respect to expenditures under the plan for which amounts may be paid from allotments for 1983, the State is not required to make any State contribution.

"(3) With respect to expenditures under the plan for which amounts may be paid from allotments for fiscal year 1984 or 1985, if the State has a State unemployment rate for the fiscal year equal to—

"(A) 10 percent or more and such rate is—

"(i) equal to or greater than 133⅓ percent of the national average total unemployment rate for that year, the State is not required to make any State contribution, or

"(ii) less than 133⅓ percent of the national average total unemployment rate for that year, the State's contribution must be equal to at least 5 percent of the sum of the minimum State contribution computed under this clause and the amount of the Federal allotment paid the State under this part for that year;

"(B) less than 10 percent, but more than 6 percent, the State's contribution must be equal to at least a percentage of the sum of the minimum State contribution computed under this subparagraph and the amount of the Federal allotment paid to the State under this part for that year, such percentage equal to 20 percent minus the product of 15 per centum and the ratio of (i) the percent difference between the State unemployment rate for that year and 6 percent, to (ii) 4 percent; or

"(C) 6 percent or less, the State's contribution must be equal to at least 20 percent of the sum of the minimum State contribution computed under this subparagraph and the amount of the Federal allotment paid to the State under this part for that year.

As used in this paragraph, the term 'State unemployment rate' means for a fiscal year for a State the average of the monthly civilian labor force unemployment rates in that State (as determined and published on a non-preliminary basis by the Bureau of Labor Statistics) for the most recent three-month period for which data are available before the beginning of the fiscal year.

"(4)(A) Except as provided in subparagraph (B), the State plan must provide for financial participation by the State in an amount not less than the State contribution required under this subsection.

"(B) A State may use premiums collected under the plan towards its State contribution required under this subsection, but such premiums may not be used to offset more than 50 percent of the State's required contribution with respect to any fiscal year.

"(g) ADMINISTRATION OF PLAN.—(1) The State plan must provide that not more than 10 percent of the expenditures under the plan for any fiscal year are for expenses for administering the plan, except that this restriction shall not apply to 10 percent of the allotment to the State for fiscal year 1983.

"(2) A State may elect to provide for the administration of part or all of its plan under this part by the single State agency (and in accordance with its plan approved) under title XIX. In such case, the State shall provide the Secretary with such information as may be reasonably necessary to identify or otherwise compute the costs of administration under title XIX which are attibutable to the administration of this part and which are to be reimbursed from amounts paid the State under this part.

"(3) If the State plan provides for any administrative functions under the plan to be performed by or through the State agency administering the State's unemployment compensation law, the State plan must make appropriate arrangements to reimburse such agency (and, to the extent the Railroad Retirement Board performs similar functions pursuant to section 2105(c), to make appropriate and similar arrangements to reimburse the Board) for its reasonable expenses of performing such functions under the plan.

"ALTERNATIVE STATE ARRANGEMENTS

"SEC. 2104. (a)(1) A State plan under this part may provide an enrollee with the voluntary option of electing to receive medical benefits through an arrangement with a health benefits plan (including a private insurer, prepaid health plan, provider, or a provider group), rather than in accordance with section 2103, if—

"(A) the scope, amount, and duration of benefits made available under the arrangement are at least equal to the scope, amount, and duration of benefits otherwise provided under the plan;

"(B) with respect to services covered under the State plan, any premiums and charges provided under the arrangement do not exceed the premiums and charges permitted under section 2103(e); and

"(C) under the arrangement, the amount of payment under the plan may not exceed the actuarial value of payments for medical benefits which the State reasonably estimates would otherwise have been made under the plan.

"(2) The State may provide that an enrollee who has exercised an election under this subsection may not terminate or modify such an election (other than for cause) for a period of up to 6 months beginning with the first month in which the election takes effect.

"(b)(1) A State plan under this part may provide an eligible individual enrolled with the State under this part with the voluntary option of electing, in lieu of otherwise receiving medical benefits under the plan, of having the State make a cash payment (in the amount determined under paragraph (2)(A)) towards the premium or similar charge of enrolling the individual (and immediate family members) in a health insurance or benefits plan described in paragraph (3).

"(2) In the case of an individual making an election under this subsection—

"(A) the amount of the cash payment by the State towards the cost of the plan shall not exceed the actuarial value of payments for medical benefits which the State reasonably estimates would otherwise have been made under the plan, and

"(B) the State plan may provide that the individual may not terminate or modify such an election (other than for cause) for a period of up to 6 months beginning with the first month in which the election takes effect.

"(3) A health insurance or benefits plan (including a private insurer, prepaid health plan, provider, or a provider group), in order to be eligible under a State

plan under this subsection must make an arrangement suitable to the State under which it provides to each individual, before the individual is enrolled with the plan under this subsection, a written description of the benefits, charges, and costs under the plan. The benefits provided under such a plan and the premiums and other charges imposed under the plan need not comply with the provisions of subsections (d) and (e) of section 2103.

"(c) A State plan may provide for an arrangement with one or more private health benefits plans under which health insurance or health benefits are made available in accordance with the plan and section 2103 for all individuals in the State eligible under the plan.

"REPORTS, AUDITS, AND MISCELLANEOUS PROVISIONS

"SEC. 2105. (a) Each State shall prepare and submit not later than February 1, 1985, to the Secretary and each House of Congress (in such form and manner as the Secretary determines, after consultation with the States and the Comptroller General, to be appropriate) a report on its activities through fiscal year 1984 under its plan. Such report shall include, among other items, a description of—

"(1) the criteria for eligibility of individuals under the plan and the number of individuals enrolled for benefits through the period under the plan, and

"(2) the medical benefits made available under the plan, the total amount of expenditures made under the plan through the period, the portion of such expenditures spent on inpatient and ambulatory services, and amount of expenditures under the plan per enrollee through the period.

"(b)(1) The provisions of sections 506 (other than subsection (a)) and 508 of this Act (relating to audits and access to information and nondiscrimination under the maternal and child health services block grant) shall apply to expenditures and activities under this part in the same manner as those provisions apply to expenditures and activities under title V; and for this purpose any reference to that title in any of those sections shall be deemed a reference to this part.

"(2) The provisions of section 1909 shall apply to State plans under this part in the same manner as they apply to State plans under title XIX.

"(3) A waiver granted a State under section 1115 or 1915(b), as such waiver applies to the requirements of a State plan approved under title XIX, shall be considered to be approved as a waiver of the corresponding requirements of this part.

"(4) A State plan approved under this part shall be treated as a State plan approved under title XIX for purposes of applying section 1307(d) of the Public Health Service Act.

"(5) The provisions of section 1128A shall apply to payments made from an allotment to a State under this part in the same manner as they apply to payments made from an allotment to a State under title V, and any reference to a State agency under such section shall be deemed for this purpose to be a reference to any agency or entity administering part or all of the State plan under this part.

"(c)(1) If, in a State, the State agency administering the State's unemployment compensation law is responsible for collection of weekly premiums under section 2103(e) with respect to individuals receiving unemployment compensation under that law, the Railroad Retirement Board shall be responsible for the collection of weekly premiums under such section with respect to individuals receiving unemployment compensation under the Railroad Unemployment Insurance Act and residing in that State.

"(2) In the case of other functions which a State agency administering the State's unemployment compensation law is required to perform under the State plan with respect to individuals receiving unemployment compensation under that law, the Railroad Retirement Board shall, to the extent feasible, perform such functions with respect to individuals receiving unemployment compensation under the Railroad Unemployment Insurance Act and residing in that State.

"(d) The Secretary may not delegate to the State his authority under this part to establish standards for the approval of State plans, to determine the acceptability of such plans, or to make other determinations required to be made by the Secretary under this part (including the specification of information to be contained in the report described in subsection (a)).

"PART B—OPEN ENROLLMENT, CONTINUATION, AND CONVERSION RIGHTS OF INDIVIDUALS

"REQUIREMENTS FOR EMPLOYEE HEALTH BENEFITS PLANS

"SEC. 2121. (a) Any group health plan offered by a large employer (as defined in section 2125 (1) (B)) to employees shall meet the requirements of sections 2122 and 2123 and, if applicable, section 2124.

"(b) The Secretary, after consultation with the Secretary of the Treasury, shall promulgate such regulations as may be necessary to cary out this part.

"(c) (1) The requirements of this part shall not be construed as preventing employers (under collective bargaining agreements or otherwise) from providing additional or other health care benefits respecting employees or former employees.

"(2) The requirements of this part shall not apply to employees covered under collective-bargaining agreements entered into before the date of the enactment of this title during the period covered by such agreements (as in effect on such date).

"(d) (1) For an excise tax on the expenses incurred by large employers for group health plans failing to meet the requirements of this part, see section 4912 of the Internal Revenue Code of 1954.

"(2) For a requirement that the group health plans of each State, and political subdivisions thereof, comply with the requirements of this part as a condition of payment of block grants to the State under part A, see section 2102(d) (4).

"REQUIRING OPEN ENROLLMENT FOR SPOUSES OF UNEMPLOYED WORKERS

"SEC. 2122. (a) A group health plan meets the requirement of this section only if it provides for an open enrollment period of at least 30 days duration for each married employee who is (or at a previous time was) eligible to enroll or is enrolled under the plan and whose spouse loses coverage under a group health plan due to the involuntary layoff or involuntary separation (other than for cause) from the spouse's employment. For purposes of this preceding sentence, a spouse shall not be considered to have lost coverage during any period (after the involuntary layoff or separation from employment) in which such coverage is continued and for which a contribution toward the cost of the coverage is being made by an employer, union, or entity other than the spouse.

"(b) The terms of an enrollment during a period provided under subsection (a) shall be the same as the terms (including any option for coverage of immediate family members) most recently offered with respect to the enrollment of that employee or (at the employer's option) to newly hired or other employees similarly situated, except that such enrollment may not require or discriminate on the basis of lack of evidence of insurability and if the employee was previously covered and only exercises the option to cover immediate family members the coverage of such immediate family members shall begin on the date the option is exercised.

"(c) The requirements of this section shall apply to individuals whose spouses lose coverage under a group health plan on or after January 1, 1984.

"REQUIRING CONTINUATION OF GROUP HEALTH CARE COVERAGE FOR UNEMPLOYED WORKERS

"SEC. 2123. (a) A group health plan meets the requirements of this section only if an employee covered under the plan who would otherwise lose such coverage as a result of the individual's involuntary layoff or involuntary separation (other than for cause) from employment, is provided continuation of such coverage under a group health plan meeting the requirements of subsection (b) for a period of not less than 90 days following the date of the individual's involuntary separation or layoff (except as provided in subsection (c)). If at the time of the individual's layoff or separation some or all of the individual's immediate family members also were covered under the group health plan, the health benefits coverage under this subparagraph also must cover such immediate family members, unless the individual elects otherwise.

"(b) In the case of continuation of coverage of health care benefits under subsection (a) under a group health plan—

"(1) the continued health care benefits must not be less, in amount, duration, or scope of benefits, than either the benefits provided under such group health plan or ten physician visits and nine days of inpatient hospital services in any calendar year, whichever particular benefits are less, and

"(2) the employer must provide for a contribution toward the cost of such continued health care benefits for an individual (and immediate family members) which is not less, in proportion to the cost of such continued benefits, than the proportional contribution the employer makes toward the cost of the group health plan for employees in the same classification as the individual involved.

"(c) Subsection (a) shall not be construed as requiring continuation of coverage with respect to a former employee after the date—

"(1) the individual provides written notice to the employer of his intention not to accept or continue such coverage,

"(2) the individual has been reemployed for a period of four consecutive weeks, or

"(3) the individual has failed to provide for timely payments of any premiums required.

"(d) For purposes of this section and section 2124, the term 'employee' does not include a temporary employee (as defined by the Secretary).

"(e) The requirements of this section shall apply to individuals who are involuntarily laid-off or separated from employment on or after January 1, 1985.

"REQUIRING UNEMPLOYED WORKERS COVERED UNDER INSURED GROUP HEALTH PLANS TO HAVE THE RIGHT TO CONVERT TO INDIVIDUAL POLICIES

"SEC. 2124. (a) An insured group health plan meets the requirements of this section only if an employee covered under the plan is permitted the option, during the period described in subsection (b), of securing health benefits coverage, without evidence of insurability of the individual or immediate family members, where the loss of coverage under the group health plan is the result of the individual's involuntary layoff or involuntary separation (other than for cause) from employment. If at the time of the individual's layoff or separation some or all of the individual's immediate family members also were covered under the group health plan, the individual must be given the option of securing health benefits coverage under this subsection that also covers immediate family members.

"(b) The period referred to in subsection (a) for a former employee is the 31-day period beginning on the date of the individual's layoff or separation from employment, or at the option of the individual, beginning on the last day of any continuation of health benefits coverage under the group health plan or under section 2123.

"(c) The requirements of this section shall apply to individuals involuntarily laid-off or separated on or after January 1, 1985.

"DEFINITIONS

"SEC. 2125. As used in this part:

"(1)(A) The term 'employer' does not include the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision thereof, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing, except that such term includes nonappropriated fund instrumentalities of the Government of the United States.

"(B) The term 'large employer' means an employer who, on each of some 20 days during the calendar year or the preceding calendar year, each day being in a different calendar week, employed for some portion of the day (whether or not at the same moment of time) 25 or more individuals.

"(2) The term 'group health plan' has the meaning given such term in section 162(i)(2) of the Internal Revenue Code of 1954.

"(3) The term 'insured group health plan' means a group health plan under which an entity, which is subject to the insurance laws or regulations of a State or to the laws of a State respecting hospital, medical, or dental service corporations, assumes the financial risks for paying benefits under the plan in exchange for payment of premiums under the plan.

"(4) The term 'immediate family member' means, with respect to an individual—

"(A) in the case of a married individual, the individual's spouse, and

"(B) the individual's child, if the child is under 18 years of age.

"PART C—ASSISTANCE TO HOSPITALS SERVING THE UNEMPLOYED

"GRANTS

"SEC. 2141. (a)(1) The Secretary shall make grants to hospitals meeting the requirements of subsection (b) to assist the hospitals in providing services to persons unable to pay for such services.

"(2) In making such grants, the Secretary shall—

"(A) first give priority to hospitals which are either (i) public hospitals (or hospitals operated by a public benefit corporation) or (ii) hospitals serving areas not served by a public hospital, and

"(B) then give priority to other hospitals which demonstrate that they serve a significantly disproportionate number of patients who are unemployed and who are unable to pay for hospital services.

"(b) A hospital is not eligible for a grant under this section unless the hospital—

"(1)(A) is located in an area experiencing high unemployment (as determined by the Secretary), or (B) serves primarily medically underserved populations (as defined in section 330(b)(3) of the Public Health Service Act);

"(2) serves a significantly disproportionate number of patients who have low income and who are unable to pay for hospital services;

"(3) provides services to persons without regard to their ability to pay;

"(4) provides evidence, satisfactory to the Secretary, that if the hospital is required, pursuant to an assurance under title VI or XVI of the Public Health Service Act, to make available a reasonable volume of services to persons unable to pay therefor, the hospital has made (and is making) such a volume of services available for the period for which the assistance is sought; and

"(5) offers assurances satisfactory to the Secretary that it will use the sums provided in the grant in addition to, rather than in lieu of, existing Federal, State, and local funds currently available for the purposes described in subsection (a).

"(c)(1) No grant may be made under this section unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and contain such information as the Secretary shall prescribe.

"(2) The amount of any grant under this section shall be determined by the Secretary.

"(d) The Secretary shall report to the Congress not later than March 31, 1985, and March 31, 1986, on the identity and location of hospitals provided assistance under this section and an estimate of the change in the number of individuals who are unable to pay for services and who were provided services in each of such hospitals receiving such assistance compared to the number of such individuals in the previous period.

"(e) For the purpose of making grants under this part, there are authorized to be appropriated—

"(1) for fiscal year 1984, $96,000,000,

"(2) for fiscal year 1985, $77,000,000, and

"(3) for fiscal year 1986, $60,000,000.".

(b) Part A of title XXI of the Social Security Act (as added by subsection (a))—

(1) is effective for calendar quarters beginning on or after July 1, 1983, and

(2) is repealed, effective for services furnished on or after October 1, 1985.

(c)(1) The Secretary of Health and Human Services shall cause to be published in the Federal Register a notice of the interim final regulations required to carry out part A of title XXI of the Social Security Act no later than September 15, 1983, and allow for a subsequent period of public comment thereon.

(2) The regulations with respect to part A of such title shall become effective on September 15, 1983, without the necessity for consideration of comments received, but the Secretary, after taking into consideration any such comments received respecting such part, shall by notice published in the Federal Register affirm or modify the regulations by December 31, 1983. Any such modification of such regulations shall apply only for quarters beginning on or after April 1, 1984.

(3) The Secretary of Health and Human Services, after consultation with the Secretary of the Treasury, shall prescribe on a time basis such regulations as may be necessary to implement the requirements of part B of title XXI of the Social Security Act in accordance with the effective dates contained in that part.

MISCELLANEOUS AMENDMENTS

SEC. 102. (a) Section 501(a) of the Social Security Act is amended by striking out "fiscal year 1982" and inserting in lieu thereof "fiscal years 1982 and 1983 and $483,000,000 for fiscal year 1984".

(b) Effective beginning with fiscal year 1984, paragraphs (1) through (5) of section 1108(c) of the Social Security Act (42 U.S.C. 1308(c)) are amended to read as follows:

"(1) Puerto Rico shall not exceed $77,100,000,
"(2) the Virgin Islands shall not exceed $2,600,000,
"(3) Guam shall not exceed $2,400,000,
"(4) the Northern Mariana Islands shall not exceed $600,000, and
"(5) American Samoa shall not exceed $1,300,000.".

(c)(1) Section 1866(a)(1)(F) of the Social Security Act is amended by inserting "with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located as of July 1, 1983) or" before "a utilization and quality control".

(2) The amendment made by paragraph (1) shall take effect on January 1, 1984.

TITLE II—INTERNAL REVENUE CODE AMENDMENT AND MISCELLANEOUS PROVISION

IMPOSITION OF EXCISE TAX ON CERTAIN HEALTH PLANS OF LARGE EMPLOYERS

SEC. 201. (a) Chapter 41 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subchapter:

"Subchapter B—Health Plans of Large Employers Which Do Not Meet Coverage Requirements for the Unemployed

"Sec. 4912. Tax on expenses of health plans of large employers which do not meet coverage requirements for the unemployed.

"SEC. 4912. TAX ON EXPENSES OF HEALTH PLANS OF LARGE EMPLOYERS WHICH DO NOT MEET COVERAGE REQUIREMENTS FOR THE UNEMPLOYED.

"(a) TAX IMPOSED.—In the case of a large employer, there is hereby imposed a tax equal to 10 percent of the amount of the nonqualified employee health expenses paid or incurred during the taxable year.

"(b) LARGE EMPLOYER.—For purposes of this section, the term 'large employer' has the meaning given to such term by section 2125(1) of the Social Security Act (as in effect on the day after the date of the enactment of this section).

"(c) NONQUALIFIED EMPLOYEE HEALTH EXPENSES.—For purposes of this section—

"(1) IN GENERAL.—The term 'nonqualified employee health expenses' means the expenses paid or incurred by the employer for a group health plan to the extent such expenses are allocable to a period during which such plan does not meet each requirement contained in part B of title XXI of the Social Security Act (as in effect on the day after the date of the enactment of this section) which under such part such plan is required to meet.

"(2) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given to such term by section 162(i)(2).

"(d) TERMINATION.—Subsection (a) shall not apply to amounts paid or incurred after December 31, 1986.

"(e) CROSS REFERENCE.—

"(1) For provision denying deduction for tax imposed by this section, see section 275(a)(6).

"(2) For provisions making deficiency procedures applicable to tax imposed by this section, see section 6211 et seq."

(b)(1) Chapter 41 of such Code is amended by striking out the chapter heading and inserting in lieu thereof the following:

"CHAPTER 41—PUBLIC CHARITIES; CERTAIN HEALTH PLANS OF LARGE EMPLOYERS

"Subchapter A. Public charities.
"Subchapter B. Health plans of large employers which do not meet coverage requirements for the unemployed.

"Subchapter A—Public Charities".

(2) The table of chapters for subtitle D of such Code is amended by striking out the item relating to chapter 41 and inserting in lieu thereof the following:

"Chapter 41. Public charities; certain health plans of large employers."

(3) Subparagraph (B) of section 6104(c)(1) of such Code is amended by striking out "or chapter 41 or 42" and inserting in lieu thereof ", subchapter A of chapter 41, or chapter 42".

(c) The amendments made by this section shall apply to amounts paid or incurred after December 31, 1983, in taxable years ending after such date.

MEDICARE HOSPICE AMENDMENT

SEC. 202. Section 1814(i)(2) of the Social Security Act is amended—

(1) striking out "located in a region (as defined by the Secretary)" and "for the region' 'in subparagraph (A), and

(2) by amending subparagraph (B) to read as follows:

"(B) For purposes of subparagraph (A), the 'cap amount' for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers (U.S. city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.".

I. INTRODUCTION

PURPOSE

The Committee amendment addresses some of the urgent needs of the unemployed and their families who have no health insurance protection. It provides critical, but very limited benefits in response to the acute needs of the unemployed. The Committee's action reflects the limited resources available for this assistance, as other health and social programs have been severely restricted.

The Committee amendment includes a public program that entitles States to a specified and capped amount of funds for use in establishing a State plan which targets assistance on those unemployed who have no other public or private coverage and who have been unemployed the longest. It provides funds enabling these people to be provided with a limited set of health benefits. Also, employers would be required to modify their group health benefit plans in order to assist in solving the problem of loss of health benefits coverage arising from unemployment. Both the public program and the enforcement of the requirements applying to employer health benefit plans would expire after several years. The Congress would need to take specific action to extend them. Finally, a program of block grants to hospitals serving as hospitals of last resort for unemployed people unable to meet the costs of their own care would be authorized. The Committee amendment attempts, through this three-part program, to make the most effective use of the limited funds available.

The Committee recognizes that in many localities there are organized community efforts that are attempting to meet the health care needs of the unemployed. The Committee commends, and in no way intends, to discourage these efforts.

H.R. 3021, the Health Care for the Unemployed Act, was reported from the Committee on Energy and Commerce on June 7, 1983, and sequentially referred to the Committee on Ways and Means. The Committee on Ways and Means was concerned with various aspects of the bill as reported by the Committee on Energy and Commerce including the impact and effect of the open-ended entitlement program contained in that version. Members of the Committee on Ways and Means have worked during the past several weeks in close consultation with members of the Committee on Energy and Commerce to develop the proposal contained in the substitute recommended by the Committee on Ways and Means. In reporting H.R. 3021, with its recommended substitute, the Committee on Ways and Means is careful to point out that not all aspects of its substitute properly fall within the jurisdiction of the committee. Some aspects of the committee substitute are exclusively within the jurisdiction of the Committee on Energy and Commerce; others can properly be described as within the jurisdiction of both committees and some provisions, such as the excise tax enforcement provisions relating to private insurance coverage, are solely within the jurisdiction of the Committee on Ways and Means. It is not the customary practice of the Committee on Ways and Means to exceed its jurisdictional authority in recommending legislation to the House, and it has done so on this occasion only after careful consultation with the Committee on Energy and Commerce.

GENERAL DESCRIPTION

The bill, as amended by the Committee, establishes a new Title XXI of the Social Security Act which consists of three parts: (1) a directed block grant program which entitles States to a specified amount of funds to provide health services for unemployed persons, (2) requirements on employers, enforced through the tax code, to meet certain conditions related to health insurance coverage for persons who lose employment, and (3) a discretionary Federal grant program to hospitals serving large numbers of unemployed persons without health care coverage. Funding for the bill is explicitly limited to the amount contained in the 1984 Budget Resolution: $350 million in FY 1983, $2.0 billion in FY 1984, and $1.650 billion in FY 1985. The block grant program requires States to provide a minimum amount of matching payments to receive the allotted Federal funds. The directed block grant program is repealed effective October 1, 1985; the tax enforcement provisions are repealed effective December 31, 1986.

SUMMARY OF THE AMENDMENT

Specification for the block grant program

Funding.—The bill entitles States to receive a specified and capped amount of funds to provide health care services for unemployed persons. In order to receive funding a State must:

(1) submit an approved plan for providing services, and
(2) provide specified matching funds.

Funds are allocated among the States on the basis of a three-part formula: one-third distributed on the total number of unemployed persons; one-third distributed on the number of individuals receiving

unemployment compensation and one-third on the number of individuals who have exhausted regular unemployment compensation benefits during the previous year. This allotment establishes the amount of funds a State is entitled to receive if it provides the required matching funds by the end of the fiscal year. The matching requirements are as follows:

(a) In FY 1983, no State matching funds are required;

(b) in FY 1984 and FY 1985, a State is required to provide an amount which varies between zero and 20 percent of program costs depending on the unemployment rate in the State.

In a State with 6 percent unemployment or less, the State would be required to provide a 20 percent match. As the unemployment rate increases, the required matching rate for the State would decrease until in a State with 10 percent or more unemployment, the State matching requirement would be reduced to 5 percent. Where a State unemployment rate is 10 percent or more and is also equal to or greater than 133 percent of the national average unemployment rate, such State would have no matching fund obligation.

The amount of funds to be allocated among the States for the block grant program is $350 million in FY 1983, $1.869 billion in FY 1984, and $1.538 billion in FY 1985. There would be a separate allocation of $35 million to increase the current ceilings on Federal medicaid funds available to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands and American Samoa. (Other funds provided for in the Budget Resolution are allocated to the Federal discretionary grant program to hospitals serving the unemployed).

Eligibility.—Each State would have flexibility in determining the persons eligible for services under the program in that State. However, States would be required to meet certain conditions with respect to who could be covered:

First, in order to be eligible, a person must be unemployed or a member of the immediate family (spouse or child under 18) of an unemployed person.

Second, a person could not be covered in the program if he or she is covered through any program of health care coverage for which a contribution is made by an employer or if that person has been determined to be eligible for medicaid benefits.

Third, no person could be covered in the program if he or she had a working spouse with access to health care coverage with an employer contribution.

In general (except as specified below), a State would be required to establish the eligible population from persons (and their families) who are receiving unemployment compensation or who received unemployment compensation within the previous two years. A State would be required to provide coverage for persons and their families unemployed for 1 year or longer before other persons would be covered. If a State determines it cannot cover all of these persons with the funds available, it may establish a different classification based on length of time unemployed (with priority to those who have been unemployed longest). If within whatever standard is established for length of time of unemployment all persons cannot be covered, then at a minimum, children under 5 and pregnant women must be covered. The State could not apply an income or resources test except as provided below.

In addition, a State must spend 5 percent of the Federal dollars to provide services to any person (and the individual's family) who is unemployed, was previously employed as specified by the State and meets such financial or medical needs standards as the State plan specifies. However, for this group, the State may not spend more than 5 percent of the Federal dollars plus the State contribution less all premiums which are collected.

Premiums.—A State would be allowed to impose a premium of no greater than 5 percent of the unemployment benefit received by an individual. Enrollment would be voluntary with the individual. However, an individual who elects not to pay the premium would not be eligible for the program. The premium amount could be deducted from the UC check for individuals who opt to enroll. Additionally, a State would be allowed to impose a premium on persons eligible for the program but not receiving UC as long as that premium did not exceed 2 percent of the average UC payment in the State. However, premiums may not be imposed on any individual who is eligible because of the financial and/or medical needs standard as specified by the State.

Benefits.—A State would have flexibility in designing the benefit package available to covered individuals subject to the following limitations:

(1) Benefits would be uniform for all covered persons;

(2) Benefits would be limited to inpatient and outpatient hospital services, physician and clinic services, family planning services, nurse-midwife services, lab and X-ray services, and prescribed drugs;

(3) At least prenatal, delivery, post partum, and well baby services must be provided. The package must also include both inpatient and ambulatory services. Limitations on the amount, duration and scope of services would be established by the State except—

There could be no limits imposed on prenatal, delivery, post partum and well baby services except for limits of medical necessity;

The State may establish the number of days of hospital care covered, provided that coverage must begin with the initial day of hospital care in the coverage period for each individual; and

All payments for benefits would be secondary to payments made by any public or private insurance plan.

Copayments.—A State must impose the maximum copayment allowed under medicaid for physicians and other noninstitutional services and minimum deductible on hospital and other institutional services of 10 percent of the Medicaid payment for the first day of care in the facility.

Private Insurance Coverage

The bill requires all non public employers with 25 or more employees to provide for:

(a) open enrollment without requirements as to existing heatlh conditions for unemployed spouses and family members who lost health coverage, effective January 1, 1984;

(b) 90-day continuation coverage of no less than the lesser of:

(1) the benefits provided under the employer health plan or

(2) 10 physician visits and 9 in patient hospital days with the same proportional employer contribution as is made to employees' health plans, effective January 1, 1985; and

(c) in the case of insured employers, group coverage to employed persons to allow the individual a conversion option without regard to existing health conditions, effective January 1, 1985.

These provisions are enforced through an excise tax of 10 percent of the expenses for a noncomplying group heatlh plan.

In order to receive funds under the directed block grant, a State would be required to provide State and local employees with an open enrollment option for unemployed spouses by January 1, 1984, and with 90 days continuation coverage and conversion coverage by January 1, 1985.

Hospital Grant Program

The bill authorizes a discretionary Federal grant program of $96 million in FY 1984, $77 million in FY 1985, and $60 million in FY 1986 for assistance to hospitals serving as a provider of last resort to uninsured and unemployed persons.

Other Provisions

The bill contains minor provisions relating to maternal and child health, hospices, and professional review organizations.

Background and Need for Legislation

According to the Congressional Budget Office, during fiscal year 1984, 9.6 million jobless Americans will lack any form of health insurance coverage as a direct result of unemployment. When their dependents, an additional 9.5 million persons, are counted, the total number of people without health insurance coverage rises to 19.1 million. These workers and their families have no protection against the high costs of health care. As a result, their access to needed hospital and medical services, and their health status, may be seriously compromised.

The majority of workers in the American labor force (together with the dependents of these workers) are covered under some type of group health insurance or group health benefits plan through their place of employment. Group health benefits are relatively inexpensive for many employees and their dependents because group coverage usually costs less than individually-purchased insurance and because employers ordinarily pay most or all of the premiums charged for such coverage. Most workers who become unemployed for a period of more than a month or two lose these benefits, and must seek more coverage on a non-group basis. This individual coverage is generally more expensive and less adequate than group coverage, and may not be available to high-risk unemployed individuals at all. Moreover, the unemployed workers must also pay the entire costs of this insurance just when they are faced with a significant reduction in their incomes.

In general, the unemployed who lose employer-based health insurance protection are unable to obtain coverage under existing public programs. Medicare is limited to the aged and seriously disabled. State Medicaid programs are limited to certain categories of very poor people; the eligibility criteria tend to exclude the unemployed and their families.

The unemployed face two types of barriers to Medicaid eligibility. First, there are categorical requirements. Medicaid eligibility for families is tied to actual or potential receipt of cash assistance under the Aid to Families with Dependent Children (AFDC) program. Single unemployed individuals and childless unemployed couples can never gain AFDC or medicaid eligibility. Intact unemployed families are generally unable to obtain Medicaid benefits, although some States make coverage available. As of December, 1982, 21 States and the District of Columbia extended AFDC coverage, and therefore Medicaid benefits, to intact families where the principal breadwinner is unemployed. Two other States provided Medicaid coverage (but not cash assistance) to intact families where the breadwinner is unemployed, and another 6 States offered Medicaid coverage (but not cash assistance) to the children of such families.

Once a family has overcome the categorical barrier, it then confronts the stringent Medicaid income and resource requirements. Under Federal AFDC law, a family cannot qualify if the equity value it has in any real or personal property (other than the home and an automobile with an equity value of not more than $1,500) exceeds $1,000. In making this determination, a State may but need not exclude basic maintenance items, such as clothes and furniture. These assets limitations will exclude many of the unemployed. The income limitations, which are equally stringent, vary from State to State. The maximum gross earnings that a family of 3 can have and qualify for Medicaid ranges as low as $252 per month in Texas. In some States, unemployed families that meet the categorical requirements but have incomes or assets in excess of the State's cash assistance standards may qualify for Medicaid coverage as a "medically needy" recipient, but only if the State offers a medically needy program (21 States do not) and the family's income, after deducting incurred medical expenses, falls below the State's medically needy income standard.

Loss of health insurance by unemployed workers is not a new problem. However, the numbers of people affected, and the duration of such unemployment under current economic conditions, makes the matter one of particular national concern.

II. General Explanation

PART A—BLOCK GRANTS TO STATES

Appropriation and definitions (Section 2101)

The Committee amendment establishes a Federal entitlement to the States to enable them to provide health care benefits to the unemployed. The amendment authorizes the appropriation of sums sufficient to carry out this program during Fiscal Years 1983, 1984, and 1985, subject to the authorization ceiling in section 2102. The new Title

XXI of the Social Security Act that sets forth this entitlement is repealed on October 1, 1985.

Participation in the Title XXI block grant is entirely voluntary for the States. If a State elects to participate, however, then a legal relationship is created under which each State with an approved State plan under section 2103 is entitled to receive Federal payments up to the amount of its allotment under section 2102. Under this amendment, the Federal government is obligated to appropriate sums sufficient to meet qualified State claims for matching payments, up to the applicable allotments.

The Committee amendment also authorizes payments to States during FY 1983 for the purposes of planning and developing their medical benefits programs for the unemlpoyed. These funds, which may be up to 10 percent of the FY 1983 allotment, are available to the States before they submit a qualified plan. If a State indicates the intention to develop a plan, the State is entitled to up to 10 percent of its FY 1983 allotment to pay for planning costs. These planning funds may be expended in either FY 1983 or FY 1984. They are not included as administrative costs. States are not required to match these amounts for planning and development or to repay them to the Federal government, whether or not they eventually implement a medical benefits program under Title XXI.

Allotments and payments to States (Section 2102)

Under the Committee amendment, the States are entitled to receive a specified and capped amount of funds to provide health care services for unemployed persons. The total amount available for allotments to States is $350 million in FY 1983, $1.869 billion for FY 1984 and $1.538 billion for FY 1985.

For FY 1983 the total would be allocated among the States on the basis of:

(1) one-third of the total on the basis of the number of unemployed individuals in the State relative to the total number of unemployed individuals nationwide during the period from February, 1983 to April 1983 as determined by the Bureau of Labor Statistics.

(2) one-third of the total on the basis of the average number of individuals receiving regular unemployment compensation benefits in the State relative to the average number of individuals receiving unemployment compensation benefits nationwide during the period from February 1983 to April 1983.

(3) one-third of the total on the basis of the number of individuals in the State who exhausted benefits from the regular unemployment compensation program during the twelve month period from May 1982 through April 1983 relative to the nationwide total of individuals who exhausted regular unemployment compensation benefits during that time period.

The allocation formula for FY 1984 is identical. The allocation formula for FY 1985 is the same except that the dates are moved forward one year, so that under (1) and (2) above the total number of unemployed individuals is measured between February 1984 to April 1984 and, under (3), the number of individuals who exhausted regu-

lar unemployment compensation benefits is measured from May 1983 to April 1984.

Data for (2) and (3) are available from administrative data on the unemployment compensation program.

The Committee believes that a three-part allocation formula is necessary to reflect the purposes of the Committee amendment. One-third of the allocation formula is based upon the number of persons receiving unemployment compensation and one-third on the number of persons who have exhausted unemployment compensation during a specified period in the past. These allocations were used because the primary group of individuals who may be made eligible for benefits under the Committee amendment are those who are receiving unemployment compensation or have exhausted unemployment compensation within the last two years. In addition, the allocation based upon exhaustees reflects the requirement in the Committee amendment's that States give priority to those persons who have been unemployed the longest.

The Committee also included in the formula an allocation based on the total unemployment rate. This is because unemployment compensation coverage does not necessarily reflect the true picture of unemployment in a State. In many States the insured unemployment rate (i.e., the number of persons receiving UC in relation to the number of persons covered under the State unemployment compensation program) varies widely from the total unemployment rate. For example, in West Virginia, the insured unemployment rate during March, 1983 was 10.1 percent while the total unemployment rate for the same period was 20.1 percent. On the other hand, in Arkansas, the insured unemployment rate was 6.5 percent while the total unemployment rate for the comparable period was 9.6 percent. For these reasons, the Committee felt it was appropriate to include total unemployment in the allocation formula.

To encourage the timely implementation of the program, a State's allotment for FY 1984 would be reduced by one-quarter for each calendar quarter after the first calendar quarter in which the State does not have a plan in effect. The allotment is reduced to zero if it does not have a plan in effect by June 30, 1984. Thus, any State which does not have a plan in effect by March 31, 1984 would permanently lose one-fourth of its FY 1984 allotment. States which do not have a plan in effect by June 30, 1984 would lose their entire FY 1983 allotment (except for the 10 percent planning monies if a notice of intent as described below had been given), and their entire FY 1984 and FY 1985 allotments.

A State's allotment for FY 1983 and FY 1984 may be carried forward and used for expenditures in the following fiscal year for so long as the State's plan remains in effect, but not beyond the termination date of the Federal program.

The Committee amendment allows the States to phase in their block grant programs on their own schedules up to June 30, 1984, although it encourages early participation. The Governor must submit to the Secretary a notice of intent to have a plan in effect not later than June 30, 1984. If such a notice is not received by September 15, 1983, the State's entire allotment for FY 1983 will be reallocated among other States, as described below. If the notice is not received

by December 31, 1983, then the State's allotment for FY 1984 will be reallocated among the other States. Finally, if a State does not have a plan approved and in effect on June 30, 1984, then the State's allotment for FY 1984 will be reallotted among the other States.

In the Committee's view, the arrangement gives each State the certainty of a known allotment with which to plan and sufficient time to design and implement its program, and at the same time gives other States access to funds that will not be used.

The Secretary shall reallocate any monies (1) which are not reserved because the chief executive officer (Governor) has not transmitted to the Secretary of Health and Human Services a notice of intent to establish and put into effect a plan by June 30, 1984; (2) which are not used because the actual program was not in effect by a given date as described above; and (3) which are not reserved because one or more States have indicated to the Secretary that they do not intend to use the full amounts of their allotments. The Secretary shall reallocate these monies among the States in proportion to the amount otherwise allocated to such States for the fiscal year.

For reallotments under (1) the monies are reallotted among all states potentially eligible to receive allotments in the future. For example, if only one state had implemented a program by March 31, 1984, this one state would not receive the entire October through December, 1983 allotment. Allotments under (2) and (3)would be reallotted among the remaining states.

A prime consideration of the Committee is to give the States as much notice and certainty as possible. Thus, for example, the data required in the allocation formula can be ascertained by late June, which allows the Secretary to notify the States by approximately July 1 of their allotments for the next Federal fiscal year. The data used for individuals receiving regular unemployment compensation benefits and for the total unemployment rate is for the months of February, March, and April. These months are less likely to be affected by differential seasonality patterns among States, and represent the most recent available data to determine the next fiscal year's allotment. The time period used in the formula for the exhaustees is dated for the most recent twelve month period. The reason that the formula does not change within a year was, again, to give the State as much certainty as possible in its planning process.

The allotments described above determine the maximum amount of Federal financing available to the State. The actual Federal dollars flow under requirements specified by section 203 of the Intergovernmental Corporation Act of 1968. The Secretary may not make payments to a State unless the State has an approved plan and the State has made assurances satisfactory to the Secretary that the required State match is available. The Secretary shall provide for reconciliations (at least annually and more often at his discretion) of the amount of payments made to States as may be necessary to insure that payments are only used in accordance with the other specifications of the bill and that the State has contributed its required share. Amounts improperly paid to the State shall be treated as overpayments.

If a State has not submitted a report on activities by February 1, 1985, the State's allotment for FY 1985 shall be reduced by one-quarter. The Committee believes that the program needs to be care-

fully evaluated and examined in early 1985 to determine what the program has accomplished. In order to accomplish this objective the Committee needs data from the States. These requirements are not burdensome and primarily reflect the informational needs pursuant to an efficient and well-managed program.

State contributions.—In general, the State is responsible for all expenditures under this program in excess of the Federal allotment to the State. In addition, depending upon the State's unemployment rate, as defined by part (1) of the allocation formula, the State is required to match the amount of Federal expenditures as provided in section 2103(f) of the Committee amendment. These required matching funds must be provided by the State and not be passed through to any political subdivision of the State.

In Fiscal Year 1983, no State matching funds are required. In Fiscal Years 1984 and 1985 a State is required to provide an amount which varies between 0 and 20 percent of program costs depending on the unemployment rate in the State.

In a State with 6 percent unemployment or less, the State would be required to provide a 20 percent match. As the unemployment rate increases, the required matching rate for the State would decrease until in a State with 10 percent for more unemployment, the State matching requirement would be reduced to 5 percent. Where a State unemployment rate is 10 percent or more and is also equal to or greater than 133 percent of the national average unemployment rate, such State would have no matching fund obligation.

For example, in a State receiving a Federal allotment of $100 million and which has a 6 percent unemployment rate, the required State match would be $25 million or 20 percent of the Federal allotment plus the required State contribution. If, in this same State, the unemployment rate were 10 percent, the required State match would be $5.26 million or 5 percent of the Federal plus State amounts. As unemployment rates increase from 6 to 10 percent, the required matching funds would decline proportionately.

The Committee believes that the unemployment rate is an appropriate index upon which to judge the State's ability to provide funds for the purposes of this bill. The Committee believes that both States and Federal governments have a responsibility to provide health care for the unemployed and thus most States should provide at least a small amount of financing. In addition, the Committee felt that the States would have more incentive to manage and administer the program in an efficient manner if the State had a financial stake in the program. However, the Committee recognizes that some States cannot reasonably be expected to contribute. Thus, under the Committee amendment States with an unemployment rate of 10 percent or more and with an unemployment rate at or above 133 percent of the national average, would not be required to contribute.

A State would be entitled to receive funds up to the maximum amount of the block grant funds allocated to the State; it could also draw lesser amounts if it contributed a lesser amount of State matching funds. For example, if a State was entitled to a maximum of $80 million and was required to provide matching funds to make up 20 percent of program costs, it could contribute matching funds of $20

million and receive the full $80 million, or it could limit its contribution to $10 million and receive only $40 million.

In a similar manner, if a State is entitled to a Federal allotment of $100 million and has a required State contribution of $10 million but only spends $60 million under the program, the required State contribution is $6 million.

In the table below, the Federal allotment to each State for Fiscal Year 1983 and 1984 as provided by the Committee amendment are shown. In addition, the required State match assuming the State uses the entire Federal allotment is shown. The State match in percentage terms is shown in column 5 rounded to the nearest percent. However, in actual practice, this percentage would be calculated to a higher degree of precision.

For example, the table shows that the 1983 Federal allotment to Alabama is $6.3 million and the required State match is zero. The Fiscal Year 1984 Federal allotment is $33.6 million with no required State match because their unemployment level is above 133 percent of the national average. The total amount of the required State contributions in Fiscal Year 1984 is $130 million. (The table does not provide information for FY 1985 because the necessary data is not currently available.)

AMOUNT OF FEDERAL ALLOTMENTS AND REQUIRED STATE MATCHING AMOUNTS
FOR FISCAL YEARS 1983 AND 1984

State	1983 Federal Allotment (in millions)	1983 State Match	1984 Federal Allotment (in millions)	1984 State Match	1984 State Match (Percentages)	% of total Federal $
Alabama	6.3	0	33.6	0	0	1.80
Alaska	1.2	0	6.3	.3	5	.34
Arizona	3.5	0	18.9	1.0	5	1.01
Arkansas	3.0	0	15.9	1.0	6	.85
California	44.0	0	234.5	12.4	5	12.55
Colorado	4.0	0	21.5	2.1	9	1.15
Connecticut	3.6	0	19.2	3.0	14	1.03
Delaware	.6	0	3.4	.5	15	.18
D.C.	1.1	0	5.9	.3	5	.32
Florida	9.0	0	48.0	4.7	9	2.57
Georgia	6.4	0	34.7	5.0	13	1.86
Hawaii	.8	0	4.8	1.2	20	.25
Idaho	1.9	0	10.0	.5	5	.54
Illinois	22.2	0	118.7	6.3	5	6.35
Indiana	9.0	0	48.0	2.5	5	2.57
Iowa	4.5	0	24.1	1.4	6	1.29
Kansas	3.1	0	16.7	3.3	17	.89
Kentucky	5.8	0	30.8	1.6	5	1.65
Louisiana	7.6	0	40.4	2.1	5	2.16
Maine	1.8	0	9.7	.5	5	.52
Maryland	5.0	0	26.8	3.7	12	1.43
Massachusetts	7.5	0	40.1	6.5	14	2.15
Michigan	19.5	0	103.9	0	0	5.56
Minnesota	6.5	0	34.9	2.1	6	1.87
Mississippi	3.5	0	18.7	1.0	5	1.00
Missouri	6.7	0	36.1	1.9	5	1.93
Montana	1.2	0	6.6	.4	6	.36
Nebraska	1.7	0	9.1	1.7	16	.49
Nevada	1.7	0	9.3	.5	5	.50
New Hampshire	.8	0	4.4	.7	15	.23
New Jersey	12.3	0	65.9	7.7	11	3.53
New Mexico	1.5	0	8.3	.4	5	.44
New York	22.8	0	121.6	9.0	7	6.51
North Carolina	7.7	0	41.3	2.9	7	2.21
North Dakota	.9	0	5.0	.8	13	.27
Ohio	19.9	0	106.4	5.6	5	5.69
Oklahoma	4.0	0	21.4	2.4	10	1.15
Oregon	5.0	0	26.8	1.4	5	1.43
Pennsylvania	22.8	0	122.0	6.4	5	6.53
Rhode Island	1.2	0	9.3	.5	5	.50
South Carolina	4.6	0	24.6	1.3	5	1.32
South Dakota	.4	0	2.3	.4	17	.12
Tennessee	7.0	0	37.6	2.0	5	2.01
Texas	15.7	0	83.6	9.8	10	4.47
Utah	2.0	0	10.7	.7	6	.57
Vermont	.7	0	3.7	.5	13	.20
Virginia	4.9	0	26.1	4.2	14	1.39
Washington	7.5	0	40.3	2.1	5	2.16
West Virginia	4.1	0	22.1	0	0	1.18
Wisconsin	9.3	0	49.6	2.6	5	2.65
Wyoming	1.0	0	5.3	.3	5	.29
TOTAL	350.0	0	1,869.0	130.0	7	100.00

NOTE: Preliminary estimates which are subject to change.

State plans for medical benefits for the unemployed (Section 2103)
General requirements.—The Committee amendment establishes a directed block grant, under which the Federal funds made available to the States are to be used for certain specified purposes. State discretion under this block grant is broad but not unlimited. The requirements within which participating States must operate are set forth in the form of a State plan for medical benefits for the unemployed. In order for a State to establish its entitlement to payment of funds from its allotment under Title XXI, the State must have in effect a plan approved by the Secretary of Health and Human Services as in conformity with the requirements of section 2103.

The State plan must provide for making medical benefits available to eligible individuals who have voluntarily enrolled in the plan. The State has the discretion to determine which categories of persons it will offer benefits to, consistent with the requirements of section 2103(c). These eligibility standards must be set forth in the State plan and uniformly applied. A State is free to change its eligibility categories at any time; however, any changes must also be set forth in the State's plan. Once these eligibility criteria have been established, any individual who meets them and voluntarily enrolls is entitled to have payment made on his or her behalf for the medical benefits that the State has decided to offer. In this manner, the Committee amendment attempts to assure providers who choose to participate that they will receive reimbursement for services rendered to eligible individuals. Without such assurance, the eligible unemployed may have difficulty securing access to covered services due to provider uncertainty concerning payment.

The State plan must specify the medical benefits that the State will offer to those it has chosen to make eligible. Medical benefits are defined as payment of all or part of the cost of (1) inpatient hospital services, (2) physician services, (3) outpatient hospital services and rural health clinic services, (4) laboratory and x-ray services, (5) family planning services and supplies, (6) clinic services, (7) certified nurse midwife services, and (8) prescription drugs, as those terms are defined under Federal Medicaid law. The State may limit the amount, scope, and duration of these benefits as provided in section 2103(d). It may also provide additional benefits at its own cost. As under the Medicaid program, State Title XXI plans must provide that covered services may not be arbitrarily denied or reduced to an otherwise eligible individual solely because of diagnosis, type of illness, or condition. For example, a State may not impose higher copayments on hospital inpatient mental health services than on other inpatient hospital services.

The State plan must specify the cost-sharing requirements, including premiums, copayments, and deductibles, that the State has chosen to impose on eligible individuals as permitted under section 2103(e). Individual participation in the program is entirely voluntary, and the State may not impose premium requirements on any individual who chooses not to enroll or who elects to disenroll. (A State may, of course, refuse to reenroll a person who has previously disenrolled.)

Under the Committee amendment, States are required to contribute toward the costs of providing medical benefits to the unemployed, except when State unemployment rates are extremely high. The State plan must set forth this financial participation, consistent with section 2103(f).

The State plan must provide that the State will submit the report on, and audit of, program expenditures required by section 2105. The State plan must also prohibit discrimination in the use of program funds. The Committee notes that the funds authorized to be appropriated under this directed block grant (as well as those appropriated under the hospital grant program authorized by section 2141) constitute Federal financial assistance for purposes of the various Federal civil rights statutes. As under the Medicare and Medicaid programs, public and private agencies, providers, and practitioners receiving funds under Title XXI are prohibited from discriminating on the basis of race, color, national origin, sex, age, or handicap.

Under the Committee amendment, physicians, hospitals, and other health care providers are not required to participate in the program. However, if they choose to do so, they must agree to accept as payment in full for covered services rendered to eligible individuals the amount of reimbursement provided for such services under the State's Title XXI plan, and to charge beneficiaries only the cost-sharing required under the State's plan. Eligible individuals are not liable for any amounts other than deductibles, copayments, or coinsurance amounts required under the State's Title XXI plan as permitted under section 2103(e). As under Medicaid, participating providers may not deny care or services to eligible individuals because of the individual's inability to meet a copayment or other cost-sharing requirement; the individual, of course, remains liable for the required cost-sharing amount. The State may determine reimbursement amounts and methodologies for the services it elects to cover; however, payment levels to providers under Title XXI may not exceed the payment levels for the same services under the State's Medicaid program.

The Committee has attempted to direct the limited Federal funds available under Title XXI to those situations where no other source of payment is available. The State plan must provide that it is secondary in payment to any insurance or benefit plan that provides medical benefits, including a group health plan, Medicare, Medicaid, automobile or liability insurance plans, and no-fault insurance. Any eligible individual who chooses to enroll in the State's program for the unemployed must assign to the State rights to payments for medical benefits under any insurance or benefit plan to which the individual is entitled.

While the State's Title XXI program is secondary in payment to the State's Medicaid program, the State is not required to determine that each unemployed individual applying for medical benefits under Title XXI is in fact not eligible for Medicaid. Such a requirement would be unduly burdensome on both the individual applicants and the State, particularly in those States that offer Medicaid coverage to the "medically needy," which involve complex income eligibility determinations. The State need only provide that, in the case of individuals applying for benefits who are no longer receiving unemployment compensation, it will take reasonable steps to determine whether an individual meets the requirements for "categorically needy" eligibility. The Committee does not intend that the State conduct a full-fledged eligibility determination, except in cases where this is clearly warranted. Thus, if a single unemployed individual applies for benefits, the State should not seek to determine his or her assets or income for

this purpose, since the individual is clearly ineligible for Medicaid benefits for failure to meet the categorical requirements. Similarly, if an individual happens to meet the categorical requirements for eligibility but reports assets in excess of those permitted for Medicaid, the State would not be expected to further inquire of the individual's income. In short, the State's efforts to determine Medicaid eligibility should intrude to the minimum extent possible into the financial status of the individual, consistent with the general principle that limited Title XXI funds should be reserved for those not eligible for Medicaid as "categorically needy" recipients.

Under the Committee amendment, the State Title XXI plan must meet a number of the same requirements applicable to State Medicaid plans under Title XIX of the Social Security Act. Some are designed for the protection of the unemployed. The State must make the medical benefits it offers under its Title XXI plan available to the unemployed individuals it elects to cover throughout the State, and not just in certain communities (section 1902(a)(1) of the Social Security Act). The State must give applicants whose claims for Title XXI benefits are denied or are not acted on with reasonable promptness an opportunity for a fair hearing before the agency administering the program (section 1902(a)(3)). The State must provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries (section 1902(a)(7)). The State must also allow all individuals who wish to apply for Title XXI benefits to do so, and must make coverage available with reasonable promptness to those eligible (section 1902(a)(8)). In addition. the State must assure that eligible individuals may choose the hospitals, physicians, or other providers from whom they receive covered services (section 1902(a)(23)).

Other Medicaid requirements applicable to State Title XXI plans concern providers as well as beneficiaries. Some of these pertain to the establishment and enforcement of quality standards for participating providers (sections 1902(a)(9), (22)(B), (22)(D), (33)(A), (33)(B)). The States are also required to enter into agreements with participating providers under which the providers will maintain necessary records and provide the State and the Secretary upon request with information relating to claims for payment (section 1902(a)(27).

Approval and disapproval of plans.—Under the Committee amendment, States are entitled to receive Federal matching funds only if their State plans are in compliance with the requirements of Title XXI. The Committee is concerned that this program be implemented as rapidly as possible consistent with prudent expenditure of taxpayer funds. The directed block grant is designed to respond to a situation that has reached emergency proportions in many communities, and it will be in place for only two years; the Committee therefore expects the Secretary of Health and Human Services to assist the States in putting their programs in place quickly. The Committee expects that the Secretary will promulgate the required regulations no later than September 15, 1983, on an interim final basis. The Committee further anticipates that the Secretary will rapidly approve qualified State Title XXI plans on the basis of these interim regulations and will give States the opportunity to make subsequent revisions that might be required once the Secretary has revised her regulations in light of public comment and published them in final form no later than

December 31, 1983. It will not be necessary for the Secretary to redelegate her regulatory authority to the States, and under the Committee amendment she is prohibited from doing so.

Under the Committee amendment, the Secretary may not approve any State Title XXI plan which excludes any otherwise eligible U.S. citizen or resident of the State. While a State has broad discretion, consistent with section 2103(c), to determine eligibility for medical benefits, it may not impose any citizenship or residency requirements that would not be permissible under Federal Medicaid law. Thus, a State may not deny eligibility to an otherwise qualified individual because he or she has not resided in the State for a particular period.

The Committee recognizes that in many States, fiscal capacity is severely constrained. The Committee amendment attempts to minimize the financial burden on those States that choose to offer medical benefits to the unemployed under Title XXI by establishing State matching rate requirements that are substantially lower than those currently in effect under Medicaid. The Committee amendment also affords the States considerable flexibility in determining who is eligible for the program and in designing the benefits package. In addition, the Committee amendment allows States to satisfy up to half of their matching obligation with revenues generated from premiums. Finally, if a State at any time decides that it can no longer afford to provide medical benefits to the unemployed under Title XXI, it may terminate its plan and establish a date after which it is no longer obligated for expenses incurred under the plan. These features will enable States that elect to participate to keep additional fiscal demands on them to a minimum.

The Committee is concerned, however, that States may nonetheless seek to reduce eligibility or benefits under their Medicaid programs in order to free up State resources to meet the matching requirements under Title XXI. The Committee wishes to make clear that it does not intend that States transfer resources out of their Medicaid programs into Title XXI, whether to improve their Federal matching rates or for other reasons. Under the Committee amendment, the Secretary is required to disapprove, or withdraw the approval of, any State Title XXI plan if the Secretary determines that: (1) the State has discontinued coverage of dependent children under its Aid to Families with Dependent Children program for Unemployed Parents (AFDC–UP), if it had such a program in effect as of June 1, 1983; (2) the State has discontinued or reduced Medicaid eligibility for AFDC–UP families (whether or not they are receiving cash assistance) or for financially (but not categorically) eligible children, if the State Medicaid program covered such groups as of June 1, 1983; or (3) the State has made other significant reductions in eligibility or benefits in its Medicaid program in order to establish or operate a Title XXI plan. This latter requirement is not intended to bar a State from making minor changes in its Medicaid program, such as the imposition of a nominal copayment on an optional service. At the same time, however, the Secretary is not required to attempt to define a State's intent in reducing eligibility or benefits in its Medicaid program; if the effect of the State's actions upon Medicaid beneficiaries is significant, the Secretary must withdraw approval of the State's Title XXI plan.

Under the Committee amendment, the mechanism for monitoring and enforcing compliance by the States with the requirements of Title XXI parallels that under the Medicaid program. If the Secretary, after reasonable notice and opportunity for a hearing, finds that either the State plan is not in compliance or that the State's administration of the plan is out of compliance, the Secretary must withhold further payments to the State until she is satisfied that compliance has been achieved. The Committee expects that the Secretary will carefully monitor and enforce the State plan requirements for the benefit of the unemployed and the protection of the Federal interest in proper expenditure of funds. Current law provisions governing administrative and judicial review of Secretarial determinations (section 1116 of the Social Security Act) are also applicable to Title XXI.

Eligibility for Medical Benefits.—Under the Committee amendment, States would have authority, within broad Federal guidelines, to specify which unemployed persons would be eligible to enroll in the medical benefits plan. With an exception described below, no test of income or assets would be allowed in determining eligibility. The Committee believes that, insofar as possible, health benefits for the unemployed, like unemployment compensation benefits, should be provided without a test of financial need. On the other hand, some provision should be made for unemployed people who have not otherwise been made eligible and who are willing to subject themselves to a test of medical or financial need.

The basic group of individuals potentially eligible consists of people who are receiving unemployment compensation or who have received unemployment compensation within the previous two years and are unemployed (as defined by the State). "Unemployment compensation" means cash benefits payable under a State or Federal unemployment compensation law or the Railroad Unemployment Insurance Act.

At a State's option, it may continue for up to four weeks the eligibility of an individual who is reemployed. This is in recognition that health insurance coverage through the new employer may not begin until after some delay.

Because a fixed and limited amount of funding is provided for the program, a State may need to define its eligibility standards to cover fewer people than would be included if all potential eligibles were actually made eligible under the State plan. The Committee amendment requires that in doing so, the State give priority to people unemployed for the longest period of time. The State may specify a minimum period of unemployment, and then must make eligible all individuals who have been unemployed for the specified minimum period. When these individuals become entitled, members of their immediate family (spouse and children under age 18) also would be entitled to medical benefits under the plan.

The State may specify any minimum period of time it wishes, but (except as described below) must follow the principle of first making eligible all individuals who fall within the defined eligible group—that is, who meet the specified minimum length of unemployment. The Committee has included this requirement in order to give priority to individuals and families where the worker has been unemployed the longest, on the assumption that, in general, the financial difficulties

of these people are likely to be greatest, and their access to health insurance least.

The Committee recognizes, however, that there may be special reasons for permitting coverage of some people outside of the priority order outlined above that is based on length of time the person has been out of work. Accordingly, the Committee amendment provides two exceptions to the normal "length of unemployment" rules. These two exceptions permit eligibility to medical benefits based on unemployment without regard to the length of time the individual has been out of work:

(1) Under specified circumstances, the State may extend eligibility to pregnant women and to children under 5; and

(2) A portion of program funds would be set aside and used for individuals and families who are unempolyed, were previously employed, as defined by the State, and who meet whatever test of medical or financial need the State specifies.

The Committee believes that very high priority should be given to the health needs of pregnant women and of young children because of the great potential for preventing future health problems through adequate prenatal and well baby care. The amendment therefore permits a State to make pregnant women and children under age 5 eligible even where the period of unemployment of the worker is such a family is shorter than required for other unemployed workers under the State plan.

Before a State may do this, however, it must first have made eligible all unemployed people (among the pool of potential eligibles described above) who have been unemployed for a year or more. If that group has been made eligible, eligibility may be provided for pregnant women and children in families where the worker was unemployed for six months or more. Before further special priority may be given to pregnant women and young children, the State must first have made eligible all unemployed people who have been unemployed for six months or more. The coverage extended under this provision for pregnant women and children may, at the option of a State, also be extended to include all other members of the immediate family.

The State must apply at least 5 percent of the Federal fund to a second special group of people: those who (1) are unemployed (as determined under the State plan) and (2) have previously been employed (as determined under the State plan), and (3) meet whatever reasonable financial or medical needs standards the State chooses to apply under its State plan. Among the people a State might choose to provide special coverage under this 5 percent mandate are people who are within the regular pool of potential eligibles (that is, who are receiving unemployment compensation benefits or received them within the past two years) but who, except for this special coverage, would be ineligible because of the limitation on coverage based on length of unemployment under the regular program. Eligibility could also be provided to people whose previous jobs were not covered by the unemployment compensation system in the State or whose earnings or length of work were insufficient to qualify them for unemployment compensation benefits. The State would have complete flexibility to target benefits within this category based on its own standards reflected in the State plan as to the types of people for whom it is most important that health benefits be

available. As indicated, the State could apply whatever reasonable test of medical or financial need it chooses. The benefit package for this group of people would be the same as for all others entitled under the State plan. However, the State, at its option, could establish a different coverage period for this group (that is, the period during which medical benefits are available may for this group be shorter than the minimum of one year that is required for others entitled under the medical benefits program in the State).

However, the proportion of the program funds that may be used for medical benefits for this group of eligibles would be limited. Five percent of Federal funds allotted to the State would be required to be used to finance benefits for this group of people who may be subjected to a test of medical or financial need. None of the State matching funds would be required to be devoted to financing benefits for this group, but the State would have the option of using all of its State funds (matching funds plus any additional amounts the State chooses) for this purpose (not counting as State funds any premium collections). The State could not impose premiums on this group.

No individual could be eligible for medical benefits under a State plan if:

> He or she is covered (or could have been covered) under a group health plan for which a contribution is made by an employer, union or someone other than the individual or his or her spouse, or if coverage exists or could be obtained under such a plan available to the individual's spouse.
>
> He or she is determined to be eligible for medical assistance under the State plan under title XIX.

A State could at any time change the criteria for eligibility under its State plan, and may need or desire to do this in order to stay within the fixed amount of Federal funding available under its block grant allocation. But such changes in the plan must be made in a manner consistent with any State administrative procedures act or other applicable State law providing for public notice and comment. If the State chooses to restrict eligibility, it may (but is not required to) provide for continuation of the eligibility of persons already on the benefit rolls, so long as eligibility is not extended beyond the period for which these persons otherwise would have remained eligible.

A State would be required to permit an eligible individual to terminate voluntarily his or her enrollment in the plan by written notice to the State. (This is consistent with the concept of a plan in which enrollment is voluntary, and is important in any case in which premiums are imposed.)

Medical benefits.—Under the Committee Amendment, the States would have considerable flexibility in designing a benefit package within certain broad limits. The Committee Amendment establishes the services from which a State may choose in developing its benefit package. These are: inpatient and outpatient hospital, physician, clinic, rural health clinic, family planning, nurse-midwife, lab and x-ray services and prescribed drugs, as defined under Federal medicaid law.

In general, limitations on the amount, duration and scope of these services would be left to the discretion of the State. However, there are specific limitations on the State's discretion. First, the State must

provide for benefits which contain some combination of both inpatient and ambulatory services (e.g. outpatient hospital, clinic, physician).

Second, while the State may establish the maximum number of inpatient hospital days which may be covered, the State is required to begin coverage with the initial day of hospital care in the coverage period of each eligible individual. It is the view of the Committee that the individuals covered by this legislation are in particular need of the availability of first-day hospital coverage. In addition, the Committee believes it would not be inappropriate for such coverage to be continuous days of coverage beginning with the first day.

Third, the State benefit package must include prenatal, delivery, postpartum, and well-baby care. The State is prohibited from imposing any limits on the amount, duration, or scope of these benefits for mothers and children except as may be medically necessary.

The Committee is particularly concerned by reports that, in some communities with sustained high levels of unemployment, the incidence of low birthweight babies and infant mortality may be increasing. In order to reduce financial barriers to pregnancy-related services, the Committee intends that pregnant women who are eligible for benefits under this program receive the designated services, to the extent medically necessary, without reference to limitations which the State may impose on other types of services. Thus, for example, none of the hospital days associated with the delivery of a child could be counted against the mother in determining whether or not she had reached a limit on hospital days which the State might otherwise impose under its benefit package. Similarly, well-baby visits would not be included in any limitations imposed on physician or other outpatient care.

The Committee amendment includes unlimited well-baby services in recognition of the consensus in the medical profession that access to frequent and continuous preventive health services is crucial to the health of infants. If they are properly immunized and monitored, potential health and developmental problems can be diagnosed and treated, preventing the onset of permanently handicapping conditions which are not only avoidable but also costly to treat.

The medical services covered under the plan must be uniform for all groups of individuals eligible for medical benefits under the plan. The Committee notes that this does not prohibit the State from providing for variations in coverage periods where so permitted. Also, the State may, under the alternative arrangements allowed by Section 2104, offer eligible individuals an additional choice of different benefits, so long as the individual always has a choice of the same benefits as any other eligible.

A State may, if it wishes, pay for medical services furnished before an individual has enrolled in, or otherwise becomes eligible for, the program. However, it may not make payment for medical services furnished before the State plan becomes effective. Similarly, while the Committee bill expressly permits the State to continue coverage for individuals even after the State has changed its eligibility criteria, the State may not pay for medical services furnished after the termination date of the Federal program, October 1, 1985.

Premiums and copayments.—A State would be permitted to impose on an eligible individual: (1) who is receiving unemployment compensation, and (2) who elects to enroll in the health benefits program,

a premium not to exceed 5 percent of the UC recipient's weekly compensation. The percentage established by the State would be calculated on the amount payable to the enrollee for the week (without regard to any deductions or offsets actually taken thereon). At the State's option, the premium could be deducted directly from the enrollee's check.

For those eligible individuals: (1) who are not receiving unemployment compensation and (2) who choose to enroll in the health benefits program, the premium which the State would be permitted to impose would be limited to 2 percent. The percentage would be applied to the average monthly unemployment compensation benefit in the State based on the most recent data available. However, if the percentage imposed on those receiving unemployment compensation was 2 percent or less, then the percentage imposed on both recipients and non-recipients of UC must be the same.

States would not be permitted to impose any other premium or enrollment fee. The Committee amendment makes it clear that enrollment in the plan is solely at the option of the individual and that he or she may not be deemed to have enrolled in the plan simply by virtue of the State having imposed a premium. This means that a State may not establish a plan, for example, under which every person receiving unemployment compensation must pay the premium and be deemed enrolled unless the individual notifies the State that he or she does not wish to participate.

The percentage of UC benefits to be collected as premiums by the State for those receiving unemployment compensation must be uniform for all those who elect to enroll. Similarly, the percentage applicable to enrollees not receiving unemployment compensation may not vary within that group. However, the State may, at its discretion, provide standards whereby the premiums could be waived in the case of financial hardship or other good cause established by the State. This provision is intended to provide the State with the flexibility to establish conditions under which the premium may be waived. However, the State must establish, in advance, the standards under which it will permit such waivers and apply such standards uniformly.

The premiums collected under the State plan must be used to carry out the purpose of the State's program. In addition, they may not be used to offset more than 50 percent of the State's required match.

Under the Committee amendment, the State is required to impose certain deductibles and copayments. With respect to inpatient hospital services, the State is required to impose a deductible on the first day of inpatient hospital care in a coverage period of at least 10 percent. The percentage would be calculated by the State based on the established average payment for a day of inpatient hospital services under the State's medicaid plan. The State would be permitted to impose a higher deductible for such hospitals' services as long as the percentage did not exceed that permitted under Federal medicaid law (currently 50 percent).

With respect to services other than inpatient hospital services, the State would be required to impose the maximum deductions, cost sharing or similar charges which are permissible under Federal medicaid law. With respect to both inpatient and other services, the State

would not be permitted to impose deductibles, copayments or similar charges where such imposition was prohibited under Federal medicaid rules. For example, no cost sharing could be imposed on children under 18, pregnant women, emergency services or HMO enrollees.

The amounts established by the State for the deductibles and copayments must be uniformly applied. In addition, such payments may be waived under the same conditions established for waiver of the State premium.

Administration of plan.—Under the Committee amendment, States may use payments they receive under their allotments to cover their administrative costs. However, in order to maximize the amount of Federal funds available for medical services for the unemployed, the Committee amendment limits States to 10 percent of their Title XXI expenditures in any fiscal year for administration. The planning and development funds that a State receives from its FY 1983 allotment are not to be counted against the 10 percent limit on administrative funds for any fiscal year.

The Committee amendment affords the States considerable flexibility in administering their programs. A State could assign administrative functions to its Medicaid, unemployment, or other agencies, or it could contract with private insurers or other health benefits organizations for this purpose, as provided under section 2104. (In some State Medicaid programs, the claims processing function is delegated to a private fiscal agent; this same option is available to States under Title XXI).

If a State elects to use its Medicaid agency to administer part or all of its Title XXI plan, the agency's administrative costs attributable to Title XXI must be reimbursed from the administrative funds available under Title XXI; Title XIX funds are not available for this purpose. Similarly, the State must reimburse its unemployment agency for the cost of any administrative functions the agency performs as part of or in relation to the State Title XXI program. The Federal Title XXI funds available to the States for this purpose are limited to 10 percent of expenditures under the plan.

Alternative State arrangements (Section 2104)

Under the Committee amendment, States have considerable flexibility to enter into alternative arrangements for the administration of their State plans, as well as for the provision of medical benefits. With regard to the administration of the State plan, the Committee anticipates that the eligibility-related functions would involve the State unemployment agencies and the other administrative functions would be assigned to the State Medicaid agency. However, the Committee's amendment affords States the option of using other public or private agencies. For instance, in some State Medicaid programs, the claims processing function is delegated to a private fiscal agency; this option is available to States under Title XXI.

States also have considerable latitude under the Committee's amendment in how they make medical benefits available to eligible individuals. In any case, a State must allow eligible individuals to use the participating physician or hospital of their choice. In addition, the State may opt to negotiate arrangements with health benefits plans

(including private insurers, provider groups, prepaid health plans, and public hospitals) to provide the same or a different package of services to program beneficiaries. The services would have to be at least equal in scope, amount, and duration to those specified in the Committee amendment, and premiums and copayments could be no greater. The State could then offer eligible individuals the choice of regular program coverage (including freedom of choice of provider) or enrollment in the negotiated arrangement (which might include additional benefits or reduced cost-sharing) on the condition that the individual forego the use of other providers for up to 6 months.

Another option available to the State is to offer eligible individuals the choice of having the State make a payment on their behalf toward the cost of the private health insurance or health benefit plan of their choice instead of receiving benefits through the public program. The State would not pay any money to the individual directly; instead, the payment would go to the health benefits plan on the individual's behalf. The amount the payment would be the cash-equivalent of the actuarial value of the payments which the State estimates it would otherwise have made on the individual's behalf. The Committee stresses that under either option—negotiated arrangements or cash-equivalent payments—eligible individuals would always be guaranteed the additional choice of regular program coverage (including freedom of choice of provider).

A third option is available to those States that do not want to undertake the responsibility of contracting with providers of health care or administering a part or all of the State plan. Such a State could enter into an arrangement with one or more private health benefits plans under which health insurance or health benefits would be made available to all eligible individuals throughout the State. The minimum requirements of Title XXI, including the scope, amount and duration of benefits, freedom of choice or providers, and the premiums and charges which are permitted, would apply; although the arrangement with the health benefits plan or plans could provide for additional benefits to be provided or for reduced cost-sharing. The State's required contribution under the State plan would not be altered by this alternative arrangement.

Reports, audits, and miscellaneous provisions (Section 2105)

The Committee amendment commits a substantial amount of Federal resources to the States to enable them to provide medical benefits to the unemployed. The Committee expects that the States will apply these funds effectively and efficiently. In order to assure State accountability for the use of these funds, and to allow the Congress to discharge its oversight responsibilities in this regard, the Committee amendment imposes one-time reporting and auditing requirements.

Each participating State is required to submit, not later than February 1, 1985, to the Secretary and to each House of Congress a report on its activities through FY 1984 under its Title XXI plan. The report must include (1) a description of the State's eligibility criteria; (2) the number of individuals enrolled in the plan; (3) the types of medical benefits offered by the State under the plan; (4) the total amount of expenditures under the plan; (5) the expenditures made for (a) inpatient services and (b) all other services offered under the plan; and (6) the total expenditures (Federal and State)

per enrollee during the period. Failure to submit a complete report by the specified date will result in the reduction of the State's allotment for FY 1985 by one quarter.

The Committee amendment directs the Secretary, in consultation with the States and the Comptroller General, to prepare a format for the required report so that the information provided will be uniform and comparable. The Committee expects the Secretary to develop and distribute this reporting form as expeditiously as possible. In order to insure consistency and usefulness of the information; the Committee amend prohibits the Secretary from delegating to the States the specification of data to be included. In any case, the States remain obligated to submit the required information in a timely fashion.

Under the Committee amendment, each participating State is also required to audit its expenditures from payments received under Title XXI at the conclusion of the program. As under the Maternal and Child Health Services Block Grant, the audit must be conducted by an entity independent of the State agency administering the program, and it must be consistent with the Comptroller General's standards for auditing governmental organizations, programs, activities and functions, and generally accepted auditing standards. Within 30 days after completion of the audit report, a copy must be submitted to the Secretary. At the option of the State, this audit may be conducted as part of a general agency-wide audit using the Comptroller General's standards; the Committee does not intend that the same agency be audited several different times for different programs if a general audit would be more economical. Funds for the audit may be drawn from the 10 percent of the State's Title XXI outlays allowed for administrative expenses under section 2103(g).

Under the Committee amendment, any State administrative agencies, any private health insurance or benefits plans, and any providers or practitioners receiving funds under Title XXI, either directly or indirectly, are subject to the nondiscrimination provisions codified in the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, and Title VI of the Civil Rights Act of 1964. In addition, the Committee amendment prohibits all recipients of funds under Title XXI from discriminating on the ground of sex or religion. Compliance procedures parallel those established under the Maternal and Child Health Services Block Grant. Whenever the Secretary of Health and Human Services has made a finding of discrimination on the part of any entity that has received funds under Title XXI, she is required to notify the chief executive officer of the State and to request him to secure compliance. If that official has not secured compliance within 60 days, the Secretary is authorized to take remedial action or to refer the matter to the Attorney General. The Attorney General is authorized to bring a civil action in any appropriate district court of the United States for such relief as may be appropriate to remedy any prohibited discrimination.

Under the Committee amendment, persons who submit fraudulent claims for payment, make or accept kickbacks or bribes, or engage in other illegal conduct under Title XXI are subject to the criminal and civil money penalties provided under sections 1128A and 1909 of the Social Security Act.

PART B—OPEN ENROLLMENT, CONTINUATION, AND CONVERSION RIGHTS OF INDIVIDUALS (SECTIONS 2121–2125)

In the view of the Committee, the private sector shares with the public sector the responsibility to assist the unemployed and their families in paying for basic health care services. Under the Committee bill, the responsibility is limited to three elements: (1) open enrollment for the laid-off spouses of employees; (2) continuation of group health benefits for at least 90 days for laid-off employees; and (3) provision of the option to convert to individudal insurance coverage upon layoff. These requirements are phased-in to give employers and insurers the opportunity to plan for the necessary adjustments.

The open enrollment requirement is effective with respect to covered public and private employers as of January 1, 1984. The 90-day continuation requirement and the conversion requirement are effective with respect to all covered employers as of January 1, 1985. None of the requirements applies to employees covered under collective-bargaining agreements that are entered into before the date of enactment. This exemption applies only during the period covered by such collective bargaining agreements as of the date of enactment, and not to any subsequent extensions of the agreement. In this manner, the Committee bill avoids any interference in existing labor-management agreements relating to health benefits while at the same time subjecting all collectively-bargained agreements entered into after enactment to the open enrollment, continuation and conversion requirements.

The Committee bill requires thaht certain employers that offer to make contributions towards the cost of group health plans include in those plans an open enrollment provision for the unemployed spouses of employees and a continuation provision extending coverage for 90 days upon layoff. For purposes of these and subsequent requirements, a group health plan includes any plan of, or contributed to by, an employer to provide medical care to the employer's employees, former employees, or the families of such employees or former employees, directly or through insurance reimbursement or otherwise.

The following employers are subject to these open enrollment, 90-day continuation and conversion requirements: (1) employers which, during any calendar year, employ an average of 25 or more employees; and (2) States (which participate in the program) and their political subdivisions or agencies or instrumentalities of such State or political subdivisions which, during any calendar year, employ an average of 25 or more employees. No such employer is required to offer health benefits to its employees. However, if such an employer offers a group health plan, the plan must meet the bill's requirements relating to open enrollment (for all employees) and continuation (for all but temporary employees). If that plan is an insured group health plan, it must meet the bill requirements with respect to conversion. The Federal government and its territories and possessions, the District of Columbia, and any of their agencies or instrumentalities (other than non-appropriated fund instrumentalities of the Federal government) are not subject to these mandates. However, the Committee believes that the Federal government should follow the same open enrollment and 90-day continuation and conversion provisions to which other

public and private employers are subject. The employers subject to the open enrollment and 90-day continuation requirements are also subject to the requirement under section 1310 of the Public Health Service Act to offer available Health Maintenance Organizations to their employees in addition to any other group health benefits plan. Because the Committee's bill affects the same employers, the Committee expects that the Secretary, in issuing regulations implementing the requirements of the bill, will use applicable portions of the regulations currently promulgated under section 1310 with respect to which employers are defined. The Committee notes that the test of coverage is the number of employees, not the number of employees participating in any group health plan the employer has elected to offer.

Under the Committee bill, a covered employer's group health plan must provide an open enrollment period of at least 30 days for each married employee whose spouse loses coverage under a group health plan due to the involuntary layoff or involuntary separation (other than for cause) of the spouse's employment. The purpose of this requirement is to assure that those unemployed individuals who lose their health coverage as a result of job loss have an opportunity to obtain coverage for themselves (and their immediate family) through their working spouse's employer. Once this option is in effect, individuals who enroll under their spouse's plan or who fail to exercise their option to enroll will not be eligible for the public program under section 2101 of the bill. This allows limited public program funds to be targeted on those individuals with no access to private health insurance coverage through a spouse's employer.

For purposes of the open enrollment and other requirements under the Committee bill, the term "immediate family member" means, in the case of married individuals, the individual's spouse and children under 18. The Committee expects that, in defining this term in regulation, the Secretary will make clear that a child would not lose his or her coverage upon turning 18 if the child had become disabled before that time and continued to live with his or her parents as a dependent. The Committee does not intend to penalize mentally or physically disabled children who are unable to live independently by denying their parents access to health insurance coverage that extends to them.

The open enrollment requirement applies whether or not the married employee is enrolled in the employer's group health plan at the time his or her spouse becomes unemployed and loses coverage under that spouse's group health plan. As long as the married employee is or at some previous time was, eligible to enroll under the employer's group health plan, that plan must offer an open enrollment period of at least 30 days duration to that employee and his or her unemployed spouse. If at the time of the spouse's layoff or separation some or all of the immediate family members were also covered under the group health plan, the coverage offered by the married employee's employer must also be made available to the immediate family members.

The terms of this enrollment must be the same as the terms most recently offered by the employer with respect to that employee or, at the employer's option, to newly hired or other employees in similar circumstances. There are two exceptions. First, the employer's group health plan may not require evidence of insurability on the part of the employee or any immediate family member, and may not discrim-

inate against high-risk individuals eligible to enroll under the open enrollment requirement through such means as preexisting conditions or other limitations or exclusions relating to such enrollment, except to the extent that such limitations or exclusions apply to all members of an employer's plan. Secondly, if the employee was previously covered under the group health plan and only exercises the option to cover his or her unemployed spouse and immediate family members, the coverage must begin on the date this option is exercised. Employees that were not previously covered under the group health plan (and their immediate families) would be subject to the same waiting periods applicable to newly-hired employees or, at the employer's option, those applicable to the employee when he or she was first hired.

The open enrollment requirement is triggered only when the spouse of an employee loses his or her coverage under a group health plan due to involuntary layoff or involuntary separation (other than for cause). Under the Committee bill, the spouse is considered to have lost his or her group health plan coverage when the spouse's employer, union, multi-employer trust, or other entity no longer contributes toward the cost of the spouse's coverage. So long as the spouse's employer or other entity continues to contribute—regardless of the level of the contribution—the open enrollment requirement does not take effect. Because the Committee bill also imposes a continuation requirement on certain employers beginning January 1, 1985, it is anticipated that many unemployed individuals who would have switched over to their spouse's employer's group health plan through open enrollment would continue to be covered under their former employer's plan, at least for a 90-day period.

The Committee expects that the Secretary, in promulgating regulations to implement this open enrollment requirement, will make provision for reasonable notice of the rights and obligations arising under the requirement to both the employer subject to the requirement and the employees whose spouses lose their group health plan coverage due to layoff or separation.

The Committee bill also requires that covered employers offer group health plans that provide continuation coverage to employees who would otherwise lose such coverage as a result of involuntary layoff or involuntary separation (other than for cause) for at least 90 days following the date of layoff or separation. Unless the individual elects otherwise, this coverage must also be made available to the individual's spouse and children if these immediate family members were covered under the group health plan at the time of the individual's layoff or separation. Continuation coverage would terminate if the individual failed to pay required premiums, elected in writing not to accept or continue the coverage, or was reemployed for four consecutive weeks. Of course, if the individual, upon becoming reemployed, immediately enrolls in his or her new employer's group health plan, the continuation coverage would lapse when coverage became effective under the new enrollment or four weeks after consecutive reemployment, whichever occurred first.

As with the open enrollment requirement, the purpose of this continuation requirement is to limit the scarce public program dollars to those unemployed individuals without access to private health insur-

ance coverage. Election of continuation group health plan coverage is optional with the individual. However, failure to elect such coverage (and to pay any required premium) would disqualify the individual from eligibility for benefits under the public program.

It is the understanding of the Committee that, as of March, 1983, a total of 19 States (Arkansas, Connecticut, Kansas, Kentucky, Massachusetts, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Virginia, West Virginia, and Wisconsin) had enacted laws requiring that an employee covered under a health benefits plan in some manner be given the option of continuing to purchase group coverage upon layoff or termination (or both). These statutes vary from State to State; the mandatory continuation period, for example, ranges from 30 days to 18 months. In prescribing a 90-day standard, the Committee intends only to establish a uniform minimum protection for the nation's unemployed workers and their families. It is not the intent of the Committee to preclude States from establishing or maintaining longer continuation periods or other appropriate standards that exceed the protections established in the Committee bill.

Under the Committee bill, the health benefits that must be offered under this continuation coverage must be no less in amount, duration, or scope, than the lesser of (1) the benefits provided under the employer's group health plan or (2) 9 days of inpatient hospital services and 10 physician visits per year, per person. The decision as to which level of benefits to provide rests with the employer or entity responsible for offering the group health plan.

The Committee bill further requires that the employer's contribution to this continuation coverage on behalf of an individual and immediate family members must be in the same proportion to the total cost of the coverage as the employer's contribution is to the group health plan for employees in the same classification (i.e., individual or family) as the individual involved. Thus, if an individual had elected family coverage, and the employer was paying 80 percent of the premium while the individual was employed, then the employer would be obligated to pay 80 percent of the premium for the continuation coverage.

The purpose of these provisions relating to scope of continuation benefits and the employer's contribution is to minimize the financial and administrative burdens imposed on employers while assuring all employees a limited level of protection against health expenses during at least the first 3 months after involuntary layoff or involuntary separation. The Committee in no way intends to preclude or discourage employers from providing more generous continuation benefits or contributions than those required by the bill.

Under the Committee bill, covered employers are not required to make continuation coverage available to temporary employees, whether or not these employees are eligible for the employer's group health benefits during the course of their employment. The Committee does not believe it would be appropriate to extend continuation coverage to such temporary employees as students working at summer jobs or extra help in retail establishments during the Christmas season. To do so might discourage the employment of these individ-

uals or the offering of health coverage during their employment. It is the Committee's intent that, in defining the term "temporary employee," the Secretary limit this exclusion from the protection of continuation coverage to those individuals who, at the time of employment, accept employment on the understanding that it will continue for a period of less than 20 consecutive weeks, and whose employment does in fact run for a period of less than 20 consecutive weeks.

For some unemployed individuals and their families, the group health plan coverage made available through the open enrollment and continuation mandates may not be appropriate or affordable. The Committee bill therefore requires that, as of January 1, 1985, employees who lose their coverage under an insured group health plan due to involuntary layoff or involuntary separation (other than for cause) must be given the option of purchasing health benefits coverage on an individual basis without evidence of insurability (i.e., no denial of coverage due to poor health status, and no preexisting condition exclusions from coverage).

This requirement applies only to insured group health plans applicable to both commercial insurers and medical or hospital service plans. Application of the requirement is limited to employers that have a contractual relationship with one or more insurance companies. In such cases, the addition to the insurance contract of the right of a laid-off employee to convert to individual coverage would not pose significant logistical or financial difficulties. However, employers that self-insure or provide health benefits through arrangements other than an insured group health plan do not have existing contractual relationships with insurance companies. The application of this mandate on these employers would require them to enter into a new contractual relationship solely for the purpose of providing individual conversion coverage.

This individual conversion option would have to be made available during either of the following times, at the option of the individual: (1) the 31-day period beginning on the date of layoff or separation; or (2) the 31-day period beginning on the last day of any continuation of health benefits coverage. If, at the time the individual was laid-off or separated his or her spouse or children under 18 were also covered under the group health plan, the individual must also be given the option of purchasing coverage that extends to such family members.

It is the understanding of the Committee that, as of March 1983, there were 30 States which already provided for conversion options for laid-off or terminated workers similar to this new Federal requirement. (California, Colorado, Florida, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.)

An employer that offers insured group health plan coverage that is subject to this requirement is not obligated to make any contribution toward the cost of the individual conversion coverage, although the Committee does not intend to preclude or discourage any employer from doing so.

Under the Committee amendment, both taxable and tax-exempt employers are subject to an excise tax sanction under the Internal Revenue

Code for failure to comply with the open enrollment, 90-day continuation and, where applicable, conversion requirements. The sanction on employers is a non-deductible excise tax of 10 percent of the expenses paid or incurred by an employer for a group health plan which does not meet the requirements. The excise tax is repealed effective December 31, 1986.

States, their political subdivisions and the agencies and instrumentalities of the States and political subdivisions are not subject to tax enforcement for failure to comply with the open enrollment, 90-day continuation, or individual conversion requirements. In the view of the Committee, the more appropriate and effective enforcement mechanism in this case is the denial of Federal funds. The Committee bill therefore directs the Secretary of Health and Human Services to terminate Federal matching payments through the public program to any State upon a finding that the State or any of its political subdivisions (or agencies or instrumentalities of either) is not in compliance with the applicable requirements. The Secretary is to withhold such funds until he or she is satisfied that the State or its non-complying political subdivisions (or agencies or instrumentalities of either) will no longer fail to comply. Before terminating funds, the Secretary must give the State reasonable notice and an opportunity for a hearing at which individuals adversely affected by the State's noncompliance must also be given an opportunity to be heard.

Under the Committee bill, then, an unemployed worker and his or her immediate family will, by January 1, 1985, have a number of options for obtaining health protection. In a State which does not participate in the public program, if the individual has a working spouse with group health coverage, the individual will, by January 1, 1984, be able to enroll (along with any immediate family member) in the spouse's group health plan after any continuation coverage has expired. If the individual does not have a working spouse with group health coverage, the individual may convert to individual coverage immediately upon loss of employment or after the expiration of any continuation coverage (assuming the individual was covered under an insured group health plan). In a State which does participate in the public program, the individual has the additional option of receiving the limited health benefits offered under that State's Title XXI plan for a limited period of time after any continuation coverage has been exhausted. While the Committee recognizes that this set of arrangements falls short of meeting all of the health needs of all the unemployed and their families, it believes that the provisions of the bill represent a substantial improvement over current arrangements that have left millions with no protection whatsoever.

PART C—ASSISTANCE TO HOSPITALS SERVING THE UNEMPLOYED

Grants (Section 2141)

During hearings on the loss of health coverage by the unemployed, the Committee on Ways and Means heard testimony that the burden of caring for the unemployed and their families was not equally shared by all hospitals. Some hospitals—including many public hospitals—treat all persons seeking care regardless of ability to pay. Others do not accept patients without insurance coverage or other

evidence of ability to pay. Individuals in this circumstance, including the unemployed who have lost their insurance coverage, are often "dumped" onto public and other hospitals that will accept them.

In the Committee's view, such "patient dumping" practices are unacceptable. Nonetheless, it must be recognized that, as a result of such policies, the hospitals of last resort—those which are willing to treat uncovered patients—carry a disproportionate financial burden in meeting the health care needs of the unemployed and other uninsured individuals. These hospitals are often unable to raise their charges to paying patients in order to offset this charity care and bad debt. As a result, the quality of care and, in some cases, the financial solvency of these institutions is threatened.

The Committee believes that the survival of these hospitals of last resort is essential. Without these facilities, the unemployed and their families, as well as other uninsured persons, would have nowhere to turn for needed medical treatment. To enable these facilities to continue their activities during these difficult economic times, the Committee bill would establish a four-year grant program to assist hospitals in providing health care to the unemployed.

The Committee bill directs the Secretary to make grants to eligible hospitals to assist them in providing services to persons unable to pay for such services. The funds are to be used to enable these facilities to serve uncovered patients presenting themselves after a grant has been received, not to fund the charity care of bad debts associated with past patient accounts. For this purpose, the bill authorizes $96 million in fiscal year 1984, $77 million in fiscal year 1985, and $60 million in fiscal year 1986. The Committee expects the Secretary to solicit applications for, and award grants to eligible hospitals in as expeditious a manner as possible.

The Committee recognizes that these authorized amounts, while substantial, will not meet the needs of all institutions of last resort. The Committee bill therefore directs the Secretary to give first priority to eligible hospitals which are either (1) public hospitals (including hospitals operated by a public benefit corporation) or (2) private hospitals that are serving communities or parts of communities that are not within the service area of an eligible public hospital. If funds are available after the needs of priority applicants have been met, the Secretary is directed to make grants to other eligible hospitals which demonstrate a significantly disproportionate number of patients who are unemployed and who are unable to pay for hospital services.

Under the Committee bill, only hospitals that meet certain criteria are eligible for grants. The purpose of these criteria is to assure that these limited grant dollars are targeted in institutions of last resort in communities experiencing high levels of unemployment.

First, a hospital must either be located in an area experiencing high unemployment or serve primarily a medically underserved population. In determining whether a hospital serves primarily a medically underserved population, the Committee does not intend that the Secretary require a hospital to be located in an area designated under section 330(a)(3).

Second, a hospital must serve a significantly disproportionate number of low-income patients who are unable to pay for services because

they have no medicaid, medicare or private health insurance coverage. In making this determination, the Committee expects the Secretary to consider the proportion of such budget for other hospitals in the same service area. The Committee further intends that the Secretary make this determination on the basis of services provided to uninsured individuals, and not on the basis of "contract allowances" representing the difference between payment received for serving uncovered patients (including medicaid patients) and the hospital's estimate of its actual cost of providing those services. Uncovered patients for whom services are purchased through local governmental contract or subsidy are to be included by the Secretary in making this determination.

Third, a hospital must provide services to persons without regard to ability to pay. A hospital would not be eligible for assistance under this program unless its policy and practice has been, and will continue to be, to serve people without regard to their ability to pay. The hospital must not, at any time, refuse to treat any person because of his or her inability to meet a preadmission deposit, deductible, coinsurance, or similar financial requirement, or because he or she had no adequate private insurance, medicare, or medicaid coverage. The Committee intends that grants under this provision be available only to hospitals which have in effect a bona fide "open door" policy for inpatient and outpatient services, and that low-income individuals in the community be generally aware of that policy and the availability of such services.

Fourth, if a hospital has received Federal assistance in the form of a grant, loan, or loan guarantee under either titles VI or XVI of the Public Health Service Act (commonly known as the Hill-Burton program), and if the hospital is under an obligation to provide a reasonable volume of services to persons unable to pay, the hospital must demonstrate to the Secretary that it has complied with this requirement in the past and that it will comply for the period for which the grant under this program is requested.

Hospitals which received Federal funds under the Hill-Burton program must provide a reasonable volume of services to persons unable to pay (the "free care" obligation). Under applicable regulations, 42 C.F.R. Part 124, the "free care" obligation is limited to 20 years from the date of completion of construction of the Hill-Burton project. In the case of hospitals that have not yet fulfilled their entire 20-year obligation, the Secretary must be satisfied that the hospital has met its obligation for the years to date and will comply during the year for which it applies for assistance. The Committee does not want assistance under this bill to be used to pay for Hill-Burton "free care" that a facility is already obliged to provide as a result of previous Federal assistance. The Committee notes that, under their "community service" obligation, Hill-Burton facilities are also prohibited from denying emergency services to any person, regardless of ability to pay.

Finally, a hospital must satisfy the Secretary that it will use any grant funds in addition to, rather than instead of, Federal, State or local funds currently being used to provide services to persons unable to pay. The purpose of the grant program is to enable hospitals to serve additional nonpaying patients who are unemployed, not to re-

place funds that are or would be applied to the treatment of the medically indigent. The Committee intends that the Secretary withhold grant funds under this program from any hospital that reduces, in proportion to its overall revenues, its public or private funding for charity care or bad debts.

The Committee bill requires the Secretary to report to the Congress (including the House Committees on Ways and Means and on Energy and Commerce and the Senate Committee on Finance) no later than December 31, 1984, and December 31, 1985, on the results of the program. Specifically, the Committees will need to know which hospitals received grant funds, where those hospitals were located, and how many additional persons the hospitals were able to serve as a result of receiving such assistance.

MISCELLANEOUS AMENDMENTS

Maternal and child health services block grant

The Committee amendment includes the text of H.R. 2862 as reported by the Committee on Energy and Commerce on May 16, 1983. This bill increases the authorization level for the Maternal and Child Health Services (MCH) Block Grant for Fiscal Year 1984 and thereafter from $373 million to $483 million.

The Maternal and Child Health Services (MCH) Block Grant is found at Title V of the Social Security Act. Enacted in 1981 as part of the Omnibus Budget Reconciliation Act (P.L. 97–35), the MCH Block Grant makes Federal funds available to the States for the provision or purchase of a range of maternal and child health services.

Eligibility for services provided under the MCH Block Grant is determined by the States. They may elect to charge for services provided; however, no charges may be imposed for services to mothers and children whose incomes fall below the Federal poverty guidelines.

Federal funds are allocated among the States based on their proportionate share of 1981 outlays for the seven former categorical grant programs consolidated into the MCH Block Grant. In order to receive their allocations, States must match each $4 in Federal funds with $3 of its own spending on maternal and child health services.

States may not transfer MCH Block Grant funds to other block grants or use those funds for purposes other than the provision or purchase of maternal and child health and crippled children's services.

Under Title V, between 10 and 15 percent of the amounts appropriated in each fiscal year are to be withheld from the States and administered directly by the Secretary of the Department of Health and Human Services. This Federal set-aside may be applied to one or more of the following designated activities: (1) special projects of regional and national significance; (2) research; (3) training; (4) genetic disease testing, counseling, and information development and dissemination; and (5) hemophilia programs.

The program is currently authorized at a level of $373 million for FY 1983 and each suceeding fiscal year. FY 1983 appropriations are $478 million.

Current appropriations exceed the authorization level due to the enactment of the Emergency Supplemental Appropriations for

FY 1983, P.L. 98–8, commonly referred to as the Jobs Bill. This legislation contained additional funding for a number of health programs, including a supplemental appropriation of $105 million for the MCH Block Grant. Combined with the $373 million appropriated in the FY 1983 Continuing Resolution, P.L. 97–377, the $105 million Jobs Bill increment raised the total FY 1983 appropriations for the MCH Block Grant to $478 million.

By raising the fiscal year 1983 appropriations level $105 million over the fiscal year 1983 authorization level, the Congress explicitly recognized the inadequacy of that authorization level, which was established in 1981 and did not anticipate the recession the nation is now experiencing. The Congressional Budget Office estimates that, in February of 1983, about 10.2 million jobless Americans and their dependents lacked any form of health insurance coverage as a direct result of unemployment.

For many of the mothers and children in these families, the State and local clinics and private providers funded under the MCH Block Grant may be the only source of needed primary and hospital care. They are ineligible for Medicaid benefits because their families are still intact, or because they still have a few remaining assets, yet they cannot afford to purchase medical care. Particularly for pregnant women, the inability to secure needed prenatal and maternity care may have serious consequences for them and their children.

The $105 million in additional Jobs Bill funding was intended to assist the States in responding to these recession-related needs of mothers and children. These funds are available to the States only for fiscal year 1983, however. Unless the authorization level is adjusted, the appropriations level would have to be reduced to $373 million. However, the need for MCH services is not likely to decline, since the Congressional Budget Office projects that unemployment will stay above 9 percent for fiscal year 1984. States, whose own tax revenues have been reduced by the recession, would not be likely to make up the shortfall in Federal funds and, as a result, services would have to be reduced.

In the view of the Committee, it would not be prudent to prevent the Appropriations Committees from continuing to provide the current level of funding for MCH services in fiscal year 1984. Accordingly, the Committee amendment raises the MCH Block Grant authorization for fiscal year 1984 and beyond to $483 million. This amount will accommodate the fiscal year 1983 funding level of $478 million plus a $5 million allowance for inflation.

The Committee notes that the Department of Health and Human Services has taken the position that it is not authorized to accept applications from Indian tribes and tribal organizations for funding for special projects of regional or national significance under the 15 percent Federal set-aside found at section 502(a)(1) of the Social Security Act. The Secretary has misconstrued her authority. Title V places no limits on who may apply for these funds, and it is not the intent, and never was the intent, of this Committee to exclude Indian tribes or tribal organizations from consideration for funding under this authority. The Committee expects that the Secretary will, in fiscal year 1984 and thereafter, accept and give careful consideration to applications from Indian tribes and tribal organizations for funding under the

Federal set-aside to improve maternal and child health services to Native American populations.

Funding for Puerto Rico, Guam, Virgin Islands, the Northern Mariana Islands, and American Samoa

Under the Committee amendment, the allotment of funds among the States for medical benefits to the unemployed under Title XXI, as well as the appropriate level of State contribution, depends upon total monthly civilian labor force unemployment rates. It is the Committee's understanding that, in the case of Puerto Rico and Guam, this information is not available. Under the Committee amendment, therefore, participation in the Title XXI is limited to the 50 States and the District of Columbia. However, since the loss of health coverage due to unemployment is also a serious problem in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, the Committee amendment raises the current ceilings on Federal Medicaid matching rates for these jurisdictions from a total of $49 million to a total of $84 million, effective in fiscal year 1984.

Utilization and quality control peer review organizations

The Committee bill contains a technical amendment to reflect the Committee's intent that Professional Standards Review Organizations (PSROs) be treated in a manner similar to that applied to Utilization and Quality Control Peer Review Organizations (also known as Professional Review Organizations or PROs) under the Social Security Amendments of 1983 (P.L. 98–21). P.L. 98–21 required hospitals to contract with a PRO as a condition of payment under the medicare program. A full transition has not yet been made from the PSRO program to the PRO program. Thus, this amendment, would, as a transitional provision, apply a similar requirement with respect to contracts with PSROs as is applied in the case of PROs.

Hospice

The Committee bill provides a technical correction to the hospice provisions of Public Law 97–248, the Tax Equity and Fiscal Responsibility Act of 1982. P.L. 97–248 provided, as an alternative to regular medicare benefits, reimbursement for hospice care for certain medicare beneficiaries. When the Committee approved the hospice legislation a provision was included which would "cap" the maximum amount of medicare reimbursement to each hospice program, based upon the number of medicare beneficiaries enrolled in each program.

Public Law 97–248 required a cap be established based upon a formula using data on the health expenditures for the last six months of life of medicare beneficiaries whose cause of death was cancer. The data used in developing the formula, provided by the Congressional Budget Office, were erroneous. As a result, the Administration in implementing this legislation has determined that the formula would result in a cap of approximately $4,200—significantly below that which was originally anticipated by the Committee.

This technical correction would clarify the legislative language to reflect the Committee's intent as it relates to the hospice cap. The cap amount would be specified at $6,500 and would be indexed by the medical care expenditure category of the consumer price index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics.

III. Budget Effects of the Bill

1. COMMITTEE ESTIMATE

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives the following statement is made: the Committee agrees with the cost estimate prepared by the Congressional Budget Office which is included below. This estimate indicates that the outlays from the Committee amendment to H.R. 3021 would be $35 million in Fiscal Year 1983, $1,579 million in Fiscal Year 1984 and $2,316 million in Fiscal Year 1985. This is less than the amount of monies provided by the Conference agreement on the budget resolution for Fiscal Years 1983 to 1985.

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

With respect to clause 2(l)(3)(B) of rule XI of the Rules of the House, the Committee advises that the required information pertaining to new budget authority or new or increased tax expenditures, to the extent applicable to this bill, is contained in the Congressional Budget Office cost estimate included below.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of rule XI, requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by the Congressional Budget Office is provided.

U.S. Congress,
Congressional Budget Office,
Washington, D.C., June 30, 1983.

Hon. Daniel Rostenkowski,
Chairman, Committee on Ways and Means, House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 3021, the Health Care for the Unemployed Act of 1983, as ordered reported by the House Committee on Ways and Means, June 28, 1983.

Should the Committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

Alice M. Rivlin, *Director.*

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

1. Bill number: H.R. 3021.
2. Bill title: Health Care for the Unemployed Act of 1983.
3. Bill status: As ordered reported by the House Committee on Ways and Means, June 28, 1983.
4. Bill purpose: This bill would amend the Social Security Act to provide for a program of grants to states to provide health care benefits for the unemployed and for other purposes.

5. Estimated cost to the Federal Government:

	[By fiscal year, in millions of dollars]					
	1983	1984	1985	1986	1987	1988
Part A—Block grants:						
Authorization levels	350	1,869	1,538	.....	.....	.....
Outlays	35	1,483	2,239	.....	.....	.....
Part C—Assistance to hospitals:						
Authorization levels	.....	96	77	60	.....	.....
Outlays	.....	96	77	60	.....	.....
Total:						
Authorization levels	350	1,965	1,615	60	.....	.....
Outlays	35	1,579	2,316	60	.....	.....

The costs of this bill fall within budget function 550.

Basis of estimate: This bill would create a new title under the Social Security Act, Title XXI, to provide health care for the unemployed and their immediate family members through a block grant. The bill would also place requirements on employers to meet certain conditions related to health insurance coverage for persons who lose employment. Finally, the bill would establish a discretionary Federal grant program to hospitals serving a large number of unemployed persons without health care coverage.

The 1983 costs assume no expenditures for delivery of health services. However monies are assumed to be used in 1983 for planning and development of state programs. Funds for planning in 1983 are limited in the bill to ten percent of a state's allotment for the year.

The 1984 estimated costs for Part A of the bill reflect a seven and one-half month impact. This estimate assumes enactment on August 15, 1983 and implementation on March 15, 1984. The delay between the effective date and the implementation date was assumed to allow the states three months to develop state plans for medical assistance for the unemployed and to allow the Secretary of Health and Human Services three months to approve these plans. Three months was assumed because under current law the Secretary has three months to approve amendments to state Medicaid plans.

Health care services would be available to jobless workers and their immediate family members. The bill would restrict eligibility in three ways. This bill would not cover those individuals who could obtain Medicaid coverage, health coverage through an employed spouse, or coverage through a program for which a contribution was being made by an employer.

Estimated outlays assume full appropriation of authorization levels. Under Part A, the estimated outlays assume that states will start reimbursement for health care services in March of 1984. Part C of the bill authorizes the Secretary of Health and Human Services to make grants directly to hospitals in areas experiencing high unemployment in order to assist them in providing services to low-income individuals without health coverage. The bill requires that grants will only be awarded to hospitals that submit applications and receive approval by the Secretary. Outlays are assumed to begin in fiscal year 1984.

6. Estimated cost to State and local governments: This bill would require state matching for the costs of health care benefits and some of the administrative costs. Based on the state matching rates, the costs to the states would be $130 million in 1984 and $250 million in 1985.

In addition, federal funds provided under this bill may defray current state expenditures for the health care of this population. However, we are unable to estimate this budget impact on state and local governments.

7. Estimate comparison: None.

8. Previous CBO estimate: The Congressional Budget Office prepared a cost estimate of H.R. 3021 as ordered reported by the House Energy and Commerce Committee on May 24, 1983. The House Committee on Ways and Means amended H.R. 3021 in the nature of a substitute to the House Energy and Commerce Committee bill.

9. Estimate prepared by: Hinda Ripps Chaikind.

10. Estimate approved by:

C. G. Nuckols
(For James L. Blum,
Assistant Director for Budget Analysis).

IV. Other Matters Required To Be Discussed Under The Rules Of The House

1. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of the rule XI, the following statement is made: the bill H.R. 3021, as amended, was ordered favorably reported to the House of Representatives by a record vote of 21 ayes and 11 noes.

2. OVERSIGHT FINDINGS

In compliance with clause 2(l)(3)(A) of the rule XI, the Subcommittee on Health and the Subcommittee on Public Assistance and Unemployment Compensation held hearings and made findings that are reflected in this report.

3. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(l)(3)(D) of rule XI, the Committee states that the enactment of this bill is not expected to have any significant inflationary impact on prices and costs in the operation of the national economy.

4. INFLATION IMPACT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill.

The Committee believes that the bill has no measurable effect on health care prices or on consumer prices generally. The additional public expenditures for health care services provided for by the bill are small relative to current total health care expenditures and the federal budget. Therefore, the effect on demand for health services and on the federal budget is minimal.

The effect on consumer prices of the mandate for employer provision of certain health coverage is also negligible. The bill requires employers to offer open enrollment for the unemployed spouses and immediate families of employees, and, upon terminating employees, 90 days of continuation health care coverage and the right to convert to indi-

vidual coverage. Because these mandates are not fully implemented until January 1, 1985, employees will have ample opportunity to plan for these and thus the resulting effect on consumer prices is so small as to prevent calculation.

V. Section-by-Section Description

The first section provides that the short title of the Act will be the "Health Care for the Unemployed Act of 1983".

TITLE I—AMENDMENTS TO THE SOCIAL SECURITY ACT

Section 101(a) adds a new title XXI to the Social Security Act, consisting of parts A, B, and C described below.

TITLE XXI—HEALTH CARE FOR THE UNEMPLOYED

Part A—Block grants to States

Part A (sections 2101 through 2105) entitles States to funds for a block grant program to provide medical benefits to unemployed persons.

Section 2101—Appropriation and definition

Section 2101(a) authorizes appropriations for fiscal years 1983, 1984, and 1985, of sums sufficient to provide for allotments to States under the block grant program. Section 2101(b) provides for the definitions of various terms, including "immediate family benefits", which includes spouses and children under 18; "medical benefits" which are restricted to inpatient and outpatient hospital services, rural health and other clinic services, laboratory and X-ray services, family planning services, physicians' services, nurse midwife services, and prescribed drugs; 'State' which is limited to the 50 States and the District of Columbia; and 'unemployment compensation' which includes Federal unemployment insurance paid through State agencies and unemployment benefits paid by the Railroad Retirement Board under the Railroad Unemployment Insurance Act.

Section 2102—Allotments and payments to States

Section 2102(a) makes available for allotments for block grants to States $350,000,000 for fiscal year 1983, $1,869,000,000 for fiscal year 1984, and $1,538,000,000 for fiscal year 1985. Section 2102(b) provides for allotments to States by the Secretary of Health and Human Services ('HHS') based on three, equally weighted factors: (1) the number of unemployed individuals in the State (based on data of the Bureau of Labor Statistics for the period of February through April of 1983 or 1984), (2) the number of individuals in the State who have exhausted regular unemployment compensation benefits (based on Department of Labor data for the 12 months ending April 1983 or April 1984), and (3) the number of weeks of regular unemployment compensation paid in the State (based on data of the Bureau of Labor Statistics for the period of February through April of 1983 or 1984).

Section 2102(c)(1) permits each State to carry forward unused allotments for 1983 and 1984 for use in the following year. Section 2102(c)(2) denies an allotment to a State for fiscal year 1983 unless

the governor has transmitted to HHS by September 15, 1983, a notice of intent to establish a plan under this part by June 30, 1984. To receive an allotment for fiscal year 1984, the State must have transmitted such a notice by December 15, 1983, and must actually have a plan approved and in operation by June 30, 1984. For each quarter in fiscal year 1984 (after the first calendar quarter) in which the State fails to have a plan in operation, the State's allotment is reduced by one-quarter. To receive an allotment for fiscal year 1985, a State must have had a plan in effect by June 30, 1984, and have it in effect during the fiscal year, and its allotment for that year is reduced by one-quarter if it fails to submit a required report under section 2105(a) on a timely basis. Section 2102(c)(3) provides that amounts not otherwise allotted or used are reallotted among the remaining States in proportion to the amounts they would otherwise be allotted.

Section 2102(d) provides for periodic payments of the allotments to States. In order to receive payment a State must have a plan approved and in effect and have provided satisfactory assurances that it has and will make the necessary State contribution towards the cost of the plan; however, up to 10 percent of the allotment for fiscal year 1983 may be used to develop a plan. HHS is directed to reconcile at least annually the amounts paid against expenditures and State contributions under the plan to assure proper funding, and amounts improperly spent may be offset against future allotments or otherwise recovered. In order to receive payment a State must also demonstrate that group health plans offered by the State (or by political subdivisions thereof or by agencies and instrumentalities of the State or political subdivisions) are complying with the applicable requirements of part B (described below).

Section 2103—State plans for medical benefits for the unemployed

In general.—Section 2103(a) sets forth the general requirements for State plans for medical benefits for the unemployed. They are:

(1) providing medical benefits for eligible and enrolled individuals described in § 2103(c) below;

(2) providing such benefits for the minimum services described in § 2103(d) below;

(3) providing for premiums, cost sharing, and similar charges in accordance with § 2103(e) below;

(4) providing the required State contribution described in § 2103(f) below;

(5) providing for administration and expenditures in accordance with § 2103(g) below;

(6) meeting reporting, audits, and similar requirements specified in § 2105 below and providing periodic reports on the State's intended use of allotment funds;

(7) prohibiting provider payments in excess of the medicaid State plan rates and requiring providers to accept such payments as payment in full (and not denying care because of an individual's inability to pay);

(8) making payments under the plan secondary to other insurance and requiring enrollees to assign their right of payment under other insurance plans;

(9) taking steps to ascertain medicaid eligibility of those enrollees not receiving unemployment compensation; and

(10) meeting medicaid plan requirements as they require that—
(A) the plan be in effect Statewide,
(B) eligible individuals who are denied enrollment be given a fair hearing on the denial,
(C) enrollment information be treated confidentially,
(D) there be appropriate health standards established for all institutions providing health care,
(E) there be standards to assure high quality care,
(F) enrollees be given the freedom of choice to receive covered services from the qualified provider of their choice,
(G) providers have participation agreements providing access to information, and
(H) there be a plan for reviewing the appropriateness and quality of care provided under the plan.

Approval and disapproval of plans.—Section 2103(b) requires HHS to approve plans meeting these requirements, except that such a plan cannot be approved if it denies coverage to residents of the State or if HHS determines that the State has discontinued its program of aid to families with dependent children of unemployed parents (AFDC–UP) or coverage of AFDC–UP eligible individuals or children in two-parent households from its medicaid program or that the State has made other significant reductions in eligibility or benefits under its medicaid plan in order to establish or operate a plan under this part. None of this prevents a State from terminating its plan under this part at any time. Various Social Security Act provisions relating to operation of medicaid plans and administrative and judicial review of medicaid plan determinations apply to plans under this part as they apply to medicaid plans.

Eligibility for medical benefits.—Section 2103(c) requires the State plans to specify criteria for eligibility, which are to be uniformly applied and under which those who meet the standards are entitled to enroll and receive benefits under the plan. In general, in order to be eligible an individual must be unemployed and receiving (or have received within the previous 2 years) unemployment compensation, without regard to any financial or medical needs test. However, the State plan must provide (subject to section 2103(c)(5) below) for eligibility of other unemployed individuals (the "needy" group) who have previously employed if they meet financial and/or medical needs standards specified under the plan. The plan would specify standards for determining employment and unemployment. In addition, immediate family members of eligible individuals would be covered and the plan may continue enrollment for individuals previously enrolled for up to four weeks of subsequent reemployment.

Section 2103(c)(4) provides that for the non-needy enrollees the plan must set a uniform cut-off point for the period of unemployment required in order to be eligible under the plan. However, a plan can provide a shorter period of unemployment for making pregnant women and children under 5 (and, at the State's option, other immediate family members) eligible, but this shorter period cannot be less than one year or six months of unemployment unless the general period is also no greater than one year or six months of unemployment respectively.

Section 2103(c)(5) requires States to spend at least 5 percent of the

Federal allotment on services to the needy group but no more than 5 percent of its Federal allotment paid plus its net State contribution after deducting premiums.

Section 2103(c)(6) prohibits States from covering individuals who (i) have access to their own (or spouses') employer group health plans for which an outside contribution is being made or (ii) are eligible for medicaid benefits.

Section 2103(c)(7) requires any changes in eligibility to be made public and in accordance with applicable State administrative procedures and permits States, in making such changes, to phase out the eligibility of those who would lose eligibility under the changes.

Section 2103(c)(8) permits State plans to limit the benefit period of eligible individuals, but this period cannot be less than one year in the case of non-needy enrollees.

Section 2103(c)(9) requires State plans to permit eligible individuals to terminate enrollment with written notice.

Medical benefits.—Section 2103(d) specifies the medical benefits the plan must provide. These benefits must (1) include at least prenatal, delivery, post-partum, and well-baby care (without limitations of amount, duration, or scope except as to medical necessity), the first day of inpatient hospital care in the coverage period for each eligible individual, and some ambulatory services; (2) be the same for all eligible individuals (except the coverage period may be different for needy and non-needy individuals); and (3) cannot cover services furnished before the plan takes effect or after October 1, 1985 (the date of repeal of the program).

Premiums and copayments.—Section 210(e)(1) permits the plan to impose weekly premiums on non-needy enrollees receiving unemployment compensation in an amount not exceeding 5 percent of amount of unemployment compensation to which the individual is entitled and to impose weekly premiums on other non-needy enrollees in an amount not exceeding 2 percent (or, if lower, the percentage used for those receiving unemployment compensation) of the average monthly unemployment benefit in the State. The percentages chosen must be uniform within each of these groups. However, no premium can be imposed on an individual or family eligible because of its needy status. The plan can provide standards for waiver of premiums on the basis of financial hardship or other good cause. Premiums can be deducted from weekly unemployment compensation payments, must be spent for plan expenditures, and can be used towards meeting 50 percent of the required State contribution.

Section 2103(e)(2) requires State plans to impose (i) a deductible for the first day of inpatient hospital coverage equal to at least 10 percent of the average Medicaid payment, and (ii) the maximum cost-sharing charges permitted under Federal Medicaid law for ambulatory services. Such charges must be uniform, except that they may be waived on the basis of standards for financial hardship or other good cause.

State contributions.—Section 2103(f) sets forth the minimum State contributions towards the costs of the plan for different States for different fiscal year allotments. For all States for allotments for fiscal year 1983, no State contribution is required. For allotments for fiscal years 1984 and 1985—

(1) if the State's unemployment rate is above 10% and above 133⅓% of the national average, there is no required State contribution;

(2) if the State's unemployment rate is otherwise above 10%, the State must contribute at least 5 percent of the sum of the Federal allotment paid and the amount of the minimum required State contribution (summarized as the "contribution base");

(3) if the State's unemployment rate is less than 10% but more than 6%, the State must contribute a proportional share of this contribution base, the proportion increasing progressively from 5 percent to 20 percent as the unemployment rate decreases from 10% to 6%; and

(4) if the State's unemployment rate is 6% or less, the State must contribute at least 20 percent of the contribution base.

The State cannot require localities to make up the State's contribution, but may use premiums collected toward up to 50 percent of the State's required contribution.

Administration of plan.—Section 2103(g) prohibits the State from expending more than 10 percent of the amounts under the plan on administration (other than the 10 percent of the 1983 allotment which can be used for planning and development of the plan). The section permits a State to administer its plan under this part through its medicaid plan (with appropriate identification and reimbursement of costs under this part). If a State plan uses the State unemployment agency to perform administrative functions under its plan, it must make suitable arrangements to reimburse the agency for its costs of administration and must make the same arrangements with the Railroad Retirement Board when it is carrying out similar activities.

Section 2104—Alternative State arrangements

Section 2104 permits States to give enrollees the voluntary option of electing to receive benefits either—

(a) through enrollment in a private health benefits plan (under which the benefits are no less and the charges no more than those under the plan and the State's payment to the plan is actuarially the same as those which would be made under the plan) or

(b) through a cash payment in an equivalent amount good for the purchase of any health benefits plan (which may or may not have the same benefits or charges as those under the State plan) which has made proper arrangements with the State for disclosure of benefits, charges, and costs.

In the case of an enrollee who elects either such option, the State may prohibit the enrollee from opting out of the election (except for cause) for a period of up to 6 months.

Section 2104(c) also permits States to arrange with one or more private health insurers for the provision of the covered benefits under the plan to all eligible individuals in accordance with the State plan and section 2103.

Section 2105—Reports, audits, and miscellaneous provisions

Section 2105(a) requires each State to submit, not later than February 1, 1985, to HHS and to each House of Congress a report on its plan activities through fiscal year 1984, including details on eligibility criteria, number of enrollees, services covered and benefits paid. In order to insure consistency and permit proper legislative oversight

of the plans under this part, the Secretary may not under section 2105(d) delegate to the States the specification of the information which must be included in such reports.

Section 2105(b) incorporates by reference the certain provisions of the maternal and child health services block grant program (title V of the Social Security Act) relating to requiring periodic audits and access to information and prohibiting discrimination in the provision of services under State plans. The section also incorporates certain Social Security Act provisions providing criminal and civil money penalties for certain program-related offenses and provides that waivers of medicaid State plan requirements also automatically waive any corresponding requirements of plans under this part. A health maintenance organization which provides only the services required under State plans under this part to individuals enrolled under the plan is not disqualified from receiving assistance or being a 'qualified health maintenance organization' under title XIII of the Public Health Service Act because it so limits the services it furnishes to these individuals.

Section 2105(c) requires that if under a State plan the State Unemployment agency is responsible for collection of weekly premiums through deductions for its beneficiaries, the Railroad Retirement Board must provide for similar deductions for railroad unemployment beneficiaries. The section requires that Board, to the extent feasible, to also perform such other functions for its beneficiaries as the State unemployment agency performs under the plan for its beneficiaries. Note that, in such instance, section 2102(g)(3) requires States to make reasonable arrangements for reimbursement of the Board's costs in carrying out these functions.

Section 2105(d) prohibits the Secretary of HHS from delegating to the States the authority to set State plan standards, to determine State compliance with those standards, and similar functions under the program.

Part B—Open enrollment, continuation, and conversion rights of individuals

Part B imposes certain requirements on group health plans offered by certain employers to protect the interests of workers who become unemployed and who previously were (or could have been) covered under such a plan.

Section 2121—Requirements for employee health benefits plans

Section 2121 requires group health plans which are offered (or for which there is a contribution made) by employers of 25 or more employees must meet the requirements contained in succeeding sections. HHS is instructed to promulgate regulations, after consultation with the Secretary of the Treasury (viz., IRS), to implement these requirements. In order to provide a consistent Federal policy, IRS is instructed to implement the enforcement provisions of the tax code in a manner consistent with the HHS regulations. The requirements of this part do not apply to employees covered under collective-bargaining agreements entered into before the date of the enactment of this title during the period covered by such agreements (as in effect on such date) and do not prevent employers or health plans from providing additional benefits under collective bargaining agreements

or otherwise. The requirements of this part are enforced through a denial of tax deductibility to for-profit employers for expenses incurred for plans that do not comply with the requirements, through the imposition of a 50 percent excise tax on such expenses incurred by tax exempt employers, and through the qualification for a State to receive an allotment payment under part A.

Section 2122—Requiring open enrollment of spouses of unemployed workers

Section 2122 provides that the health plans subject to the requirements must provide for an open enrollment period of at least 30 days duration for each married employee who is (or at a previous time was) eligible to enroll or is enrolled under the group health plan and whose spouse loses coverage on or after January 1, 1984, under a group health plan due to the involuntary layoff or involuntary separation (other than for cause) of the spouse's employment. The terms of the enrollment must be the same as the terms (including any option for coverage of immediate family members) most recently offered with respect to the enrollment of that employee or (at the employer's option) to newly hired or other employees similarly situated.

Section 2123—Requiring continuation of group health care coverage for unemployed workers

Section 2123 requires group health plans subject to these requirements to continue coverage for at least 90 days after an employee's coverage would otherwise be terminated because of involuntary layoff or involuntary separation (other than for cause) on or after January 1, 1985. The continued benefits must be not less than the previous benefits or, if less, 10 physician visits and 9 days of hospital care a year, and the employer must contribute in the same proportion as the employer contributes with other employees. A plan is not obligated to continue coverage if the employee declines coverage or fails to pay any required premiums or after the employee is reemployed for 4 weeks. The requirements of this section and section 2124 do not apply to temporary employees.

Section 2124—Requiring unemployed workers covered under insured group health plans to have the right to convert to individual policies

Section 2124 requires group health plans, which are subject to these requirements and which are regulated under State insurance law, or State hospital, medical, or dental service law, to permit employees whose coverage would be lost because of involuntary layoff or involuntary separation (other than for cause) on or after January 1, 1985, to enroll in a health insurance plan, without regard to insurability, at the employee's cost, and during a specified 31-day period.

Section 2125—Definitions

Section 2125 provides various definitions of terms used in the part. Under such definitions, these requirements do not apply to the Federal Government and 'large employers' only include employers who, in each of 20 weeks, employed at least 25 workers (using a definition modeled after that contained in section 3306 of the Internal Revenue Code of 1954 for the inclusion of certain agricultural employers under the unemployment tax provisions).

Part C—Assistance to hospitals serving the unemployed
Section 2141—Grants

Section 2141 provides a grant program to hospitals in order to assist them in meeting costs of providing services to persons unable to pay. In making grants, priority is first given to public hospitals and hospitals serving areas not served by a public hospital and then to other hospitals which demonstrate that they serve a significantly disproportionate number of patients who are unemployed and who are unable to pay for hospital services. In order to be eligible for a grant, a hospital must—

(1) either be located in an area experiencing high unemployment or serve primarily medically underserved populations,

(2) serve a significantly disproportionate number of patients who have low income and who are unable to pay for hospital services,

(3) provide services to persons without regard to their ability to pay,

(4) demonstrate that they have met (and are meeting) any free care obligation under the Hill-Burton program, and

(5) assure that grant funds will not be used to offset existing Federal, State, and local funds.

HHS is required to make reports on the program by March 1, 1985, and by March 1, 1986, including an estimate of the number of additional people services in the hospitals receiving grants. The authorizations for grants under this part are $96,000,000 for fiscal year 1984, $77,000,000 for fiscal year 1985, and $60,000,000 for fiscal year 1986.

Section 101(b) of the bill makes the Part A block grant program effective July 1, 1983, and repeals it effective October 1, 1985.

Section 101(c) requires that HHS promptly provide interim regulations to carry out the new block grant program by September 15, 1983, and requires these regulations to be made final by December 31, 1983. It also requires HHS to promulgate regulations on a timely basis to implement the group health plan requirements of part B in order that they be in effect when such requirements become effective.

Miscellaneous amendments

Section 102(a) of the bill provides an increase in the authorization of appropriations for the maternal and child health services block grant program to $483,000,000 for fiscal years beginning with fiscal year 1984, which is identical to that contained in H.R. 2862, as reported by the Committee on Energy and Commerce.

Section 102(b) of the bill provides an increase (totaling $35,000,000 and effective beginning with fiscal year 1984) for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in the maximum amount of payment they may receive in Federal payments under their medicaid programs. The provision of this additional amount is in lieu of providing for participation of the Commonwealth and these territories under the new health benefits for the unemployed plans under the new part A.

Section 102(c) requires each medicare hospital to have in effect not later than January 1, 1984, a review agreement with the PSRO in its area (if there was one in existence as of July 1, 1983) or with a utilization and quality control peer review organization (if such an organization has a contract with HHS under part B of title XI of the Social Security Act).

TITLE II—INTERNAL REVENUE CODE AMENDMENT AND MISCELLANEOUS PROVISION

Section 201 of the bill adds a new section 4912 to the Internal Revenue Code of 1954 to provide for a 10 percent excise tax on expenses incurred by large employers for group health plans which do not meet the open enrollment, continuation coverage, and, where applicable, individual conversion option requirements contained in part B of title XXI of the Social Security Act. The provision is effective as to amounts paid or incurred after December 31, 1983, and does not apply to amounts paid or incurred after December 31, 1986.

Section 202 provides that the cap amount on average per patient payments to hospices under the medicare program will be $6,500, increased by inflation under the medical care component of the consumer price index. This reflects the original intent of Congress in enacting section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, Public Law 97–248).

VI. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE V—MATERIALS AND CHILD HEALTH SERVICES BLOCK GRANT

AUTHORIZATION OF APPROPRIATIONS

Sec. 501. (a) For the purpose of enabling each State—

(1) to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services,

(2) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and children (especially by providing preventive and primary care services for low income children, and prenatal, delivery, and post partum care for low income mothers),

(3) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI of this Act, and

(4) to provide services for locating, and for medical, surgical, corrective, and other services, and care for, and facilities for diagnosis, hospitalization, and aftercare for, children who are crip-

pled or who are suffering from conditions leading to crippling; and for the purpose of enabling the Secretary to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and crippled children, for genetic disease testing, counseling, and information development and dissemination programs, and for grants relating to hemophilia (without regard to age), there are authorized to be appropriated $373,000,000 for [fiscal year 1982] *fiscal years 1982 and 1983 and $483,000,000 for fiscal year 1984* and for each fiscal year thereafter.

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

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Part A—General Provisions

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limitation on payments to puerto rico, the virgin islands, and guam [23]

Sec. 1108. (a) * * *

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(c) The total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

[(1) Puerto Rico shall not exceed $45,000,000,

[(2) the Virgin Islands shall not exceed $1,500,000,

[(3) Guam shall not exceed $1,400,000,

[(4) the Northern Mariana Islands shall not exceed $350,000, and

[(5) American Samoa shall not exceed $750,000]

(1) Puerto Rico shall not exceed $77,100,000,

(2) the Virgin Islands shall not exceed $2,600,000,

(3) Guam shall not exceed $2,400,000,

(4) the Northern Mariana Islands shall not exceed $600,000, and

(5) American Samoa shall not exceed $1,300,000.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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Part A—Hospital Insurance Benefits for the Aged and Disabled

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conditions of and limitations on payment for services

Requirement of Requests and Certifications

Sec. 1814.(a) * * *

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Payment for Hospice Care

(i)(1) Subject to the limitation under paragraph (2) and the provisions of section 1813(a)(4), the amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations (including those authorized under section 1861(v)(1)(A)), except that no payment may be made for bereavement counseling and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

(2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program [located in a region (as defined by the Secretary)] for an accounting year may not exceed the "cap amount" [for the region] for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

[(B) For purposes of subparagraph (A), the "cap amount" for a region for a year is computed as follows:

[(i) The Secretary, using records of the program under this title, shall identify individuals (or a representative sample of such individuals)—

[(I) who died during the base period (as defined in clause (v)),

[(II) with respect to whom the primary cause of death was cancer, and

[(III) who, during the six-month period preceding death, were provided benefits under this title.

[(ii) The Secretary shall determine a national average medicare per capita expenditure amount by (I) determining (or estimating) the amount of payments made under this title with respect to services provided to individuals identified in clause (i) during the six months before death, and (II) dividing such amount of payments by the number of such individuals.

[(iii) The Secretary, using the best available data, shall then compute a regional average medicare per capita expenditure amount for each region, by adjusting the national average medicare per capita expenditure amount (computed under clause (ii)) to reflect the relative difference between that region's average cost of delivering health care and the national average cost of delivering health care.

[(iv) The "cap amount" for a region for an accounting year is 40 percent of the regional average determined under clause (iii) for that region, increased or decreased by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers (U.S. city average), published by the Bureau of Labor Statistics, from the fourth month of the base period to the fifth month of the accounting year.

[(v) For purposes of this subparagraph, the term "base period" means the most recent period of 12 months (ending before the date proposed regulations are first issued to carry out this

paragraph) for which the Secretary determines he has sufficient data to make the determinations required under clauses (i) through (iii).]

(B) For purposes of subparagraph (A), the "cap amount" for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers (U.S. city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.

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Part C—Miscellaneous Provisions

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agreements with providers of services

Sec. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(F) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (c) or (d) of section 1886, to maintain an agreement with *with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located as of July 1, 1983) or* a utilization and quality control peer review organization (if there is such an organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located) under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incured by such hospital in providing inpatient services under part A, and (i) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (ii) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, (iii) shall be not less than an amount which reflects the rates per review established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation), and (iv) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1982 for direct and administrative costs (adjusted for inflation)) of such reviews,

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TITLE XXI—HEALTH CARE FOR THE UNEMPLOYED

PART A—BLOCK GRANTS TO STATES

APPROPRIATION AND DEFINITIONS

SEC. 2101. (a) For the purpose of enabling each State to furnish necessary medical benefits for unemployed individuals and their immediate family members, there is hereby authorized to be appropriated for fiscal years 1983, 1984, and 1985 a sum sufficient to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States under allotments under section 2102 for the development and operation of plans of medical benefits for the unemployed.

(b) As used in this part—

(1) The term "group health plan" has the meaning given such term in section 162(i)(2) of the Internal Revenue Code of 1954.

(2) The term "immediate family member" means, with respect to an individual—

(A) in the case of a married individual, the individual's spouse, and

(B) the individual's child, if the child is under 18 years of age.

(3) The term "medical benefits" means payment of part or all of the cost of the care and services described in paragraphs (1), (2), (3), (4)(C), (5), (9), and (17) of section 1905(a) (subject to subdivision (A) and (B) thereof) and of prescribed drugs.

(4) The term "number of weeks of regular unemployment compensation" means, for a State for a period, the sum, for each of the weeks in the period, of the number of individuals receiving regular compensation in that week under the State's unemployment compensation.

(5) The term "regular compensation" has the meaning given such term in section 205(2) of the Federal-State Extended Unemployment Compensation Act of 1970.

(6) The term "State" includes only the fifty States and the District of Columbia.

(7) The term "unemployment compensation" means cash benefits payable to individuals with respect to their unemployment (A) under any State unemployment compensation law, (B) under any Federal unemployment compensation law administered by a State, or (C) under the Railroad Unemployment Insurance Act.

ALLOTMENTS AND PAYMENTS TO STATES

SEC. 2102. (a) There shall be available for allotments for block grants to States under this part—

(1) $350,000,000 for fiscal year 1983,

(2) $1,869.000.000 for fiscal year 1984, and

(3) $1,538.000,000 for fiscal year 1985.

(b)(1) Subject to subsection (c), the Secretary shall allot the amounts available for allotments for each fiscal year under subsection (a) among States as follows:

(A) One-third of the amount shall be allotted among the States on the basis of the relative number of unemployed individuals in the State during the applicable period compared to the number of such unemployed individuals in all the States during such period.

(B) One-third of the amount shall be allotted among the States on the basis of the relative number of individuals in the State who exhausted regular compensation during the applicable period compared to the number of such individuals in all the States who exhausted regular compensation during such period.

(C) One-third of the amount shall be allotted among the States on the basis of the number of weeks of regular unemployment compensation in the State during the applicable period compared to the number of weeks of regular unemployment compensation in all the States during such period.

(2)(A) As used in subparagraphs (A) and (C) of paragraph (1), the term "applicable period" means—

(i) for allotments for fiscal years 1983 and 1984, the three-month period beginning February 1983, and

(ii) for allotments for fiscal year 1985, the three-month period beginning February 1984.

(B) As used in subparagraph (B) of paragraph (1), the term "applicable period" means—

(i) for allotments for fiscal years 1983 and 1984, the period beginning May 1982 and ending April 1983, and

(ii) for allotments for fiscal year 1985, the period beginning May 1983 and ending April 1984.

(3) Determinations under subparagraph (A) of paragraph (1) shall be based on data of the Bureau of Labor Statistics and determinations under subparagraphs (B) and (C) of paragraph (1) shall be based on data of the Secretary of Labor.

(c)(1) A State's allotment for fiscal year 1983 or 1984 may be carried forward and used for expenditures made under the State's plan in the following fiscal year if the State's plan remains in effect in that following fiscal year.

(2)(A) If the chief executive officer of a State has not transmitted to the Secretary by September 15, 1983, a notice on behalf of the State of the State's intent to establish and have in effect in the State, not later than June 30, 1984, a plan under this part, the State's allotment for 1983 shall be reduced to zero.

(B)(i) If the chief executive officer of a State has not transmitted to the Secretary by December 15, 1983, a notice on behalf of the State of the State's intent to establish and have in effect in the State, not later than June 30, 1984, a plan under this part, the State's allotment for 1984 shall be reduced to zero.

(ii) A State's allotment for fiscal year 1984 shall be reduced by one-quarter for each calendar quarter (after the first calendar quarter) in which the State does not have a plan approved and in effect under this part and shall be reduced to zero if the State does not have such a plan approved and in effect by June 30, 1984.

(C) A State's allotment for fiscal year 1985 shall be reduced to zero if the State does not have a plan approved and in effect under this part by June 30, 1984.

(D) If a State has not submitted a report on its activities under its plan in accordance with section 2105(a) by February 1, 1985, the State's allotment for fiscal year 1985 shall be reduced by one-quarter.

(3) To the extent that the total amount available for allotments under this part for a fiscal year is not otherwise allotted to States due to a reduction under paragraph (2) or because some States have indicated in their reports to the Secretary under section 2103(a)(6) that they do not intend to use the full amount of such allotments (including any reallotment under this paragraph) or to carry forward excess amounts under paragraph (1), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

(d)(1)(A) From the sums appropriated therefor and the allotments available under this section and subject to the succeeding paragraphs under this section and subject to the succeeding paragraphs of this subsection, the Secretary shall make payments as provided by section 6503 of title 31, United States Code, to each State from its allotment.

(B) Any amount paid to a State for fiscal year 1983 or 1984 and remaining unobligated at the end of such year shall remain available to such State for obligation in the succeeding fiscal year if the State has in effect a plan under this part during that succeeding fiscal year.

(2)(A) Except as provided in subparagraph (B), the Secretary may not make payments to a State under paragraph (1) for a fiscal year unless—

(i) the State has a plan approved and in effect under this part,

(ii) the State has made assurances satisfactory to the Secretary that the State will provide for any State contribution required under section 2103(f) towards expenditures under the plan for that fiscal year, and

(iii) the State has provided for (or made arrangements satisfactory to the Secretary for the provision of) any such State contribution for any previous fiscal year.

(B) With respect to payments from the allotment for fiscal year 1983, the Secretary may make payment to a State without a plan under this part, except that such payment may not exceed 10 percent of the State's allotment for that year and may only be paid for expenses incurred in the planning and development of such a plan.

(3) The Secretary shall provide for such reconciliations (not less frequently than annually) of the amount of the payments made to States as may be necessary to insure that such payments are only used in accordance with this part and that States contribute the required share towards expenditures under the plans under this part. Amounts improperly paid shall be treated as overpayments, and the Secretary may offset such amounts from subsequent allotments under this part or may otherwise recover such amounts.

(4) As a condition of payment to the State under this part, the State must provide assurances satisfactory to the Secretary that each group health plan offered by the State, by any political subdivision thereof, or by any agency or instrumentality of the State or a political subdivision thereof, meets the requirements of part B as they would apply if section 2125(1)(A) did not apply with respect to that State, subdivision, agency, or instrumentality. If the Secretary,

after reasonable notice and opportunity for a hearing to a State, finds that it or any of its political subdivisions, or any agency or instrumentality of the State or its political subdivisions, has failed to comply with the previous sentence, the Secretary shall terminate payments to such State under this part and notify the chief executive officer of such State that further payments under this part will not be made to the State until the Secretary is satisfied that there will no longer be any such failure to comply.

STATE PLANS FOR MEDICAL BENEFITS FOR THE UNEMPLOYED

SEC. 2103. (a) IN GENERAL.—Except as provided in section 2104, a State plan for medical benefits for the unemployed must—

(1) provide for making medical benefits (as defined in section 2101(b)(3)) available to eligible individuals voluntarily enrolled under the plan for services consistent with subsection (c);

(2) provide for making medical benefits available for such amount, duration, and scope of services (within those described in section 2101(b)(3)) as the State plan may specify consistent with subsection (d);

(3) provide for the imposition of premiums, enrollment fees, and similar charges, and for deductions, cost sharing, and similar charges only in accordance with subsection (e);

(4) provide for financial participation by the State in a manner consistent with subsection (f);

(5) provide for administration of the plan and expenditures under the plan in accordance with subsection (g);

(6) provide for reports and audits and nondiscriminatory practices in accordance with section 2105 and for periodic reports to the Secretary on the portions of the allotment to the State for each fiscal year which the State intends to use and the portions of such allotment which may be reallotted among the other States under section 2102(c)(3);

(7) provide that—

(A) the amount of payment to persons providing services covered under the plan may not exceed the amount of such payment that is provided for such services under the State's plan under title XIX, and

(B) each such person must agree to comply with the conditions of subsection (e) respecting limitations on the charges that may be imposed on beneficaries for receipt of covered services (and the provisions of section 1916(c) shall apply to such providers in the same manner as they apply to providers under a State plan under title XIX);

(8) provide that the plan—

(A) shall be secondary in payment to any insurance or benefit plan (including a group health plan, the insurance programs or a State plan under titles XVIII and XIX of this Act, an automobile or liability insurance plan, and no fault insurance) which provides medical benefits, and

(B) shall require each individual enrolled in the plan, as a condition of enrolling in the plan, to assign to the State all rights to payments, under a plan described in subparagraph (A), to which the individual may be entitled;

(9) provide that in the case of an individual enrolling for benefits under the plan who is not receiving unemployment compensation, the State will take reasonable steps to determine the eligibility under section 1902(a)(10)(A) of the individual for assistance under the State plan approved under title XIX; and

(10) meet the requirements specified in paragraphs (1), (3), (7), (8), (9), (22)(B), (22)(D), (23), (27), (33)(A), and (33)(B) of section 1902(a) in the same manner as such requirements apply to State plans under title XIX.

(b) APPROVAL AND DISAPPROVAL OF PLANS.—(1) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes as a condition for eligibility for medical benefits under the plan any citizenship requirement which excludes any citizen of the United States or any residence requirement which excludes any individual who resides in the State.

(2) The Secretary shall disapprove, or withdraw the approval of, any plan of a State under this part if the Secretary determines that—

(A) the State provided for eligibility, under its plan under section 402 as of June 1, 1983, of dependent children described in section 407 (relating to dependent children of unemployed parents) and, after such date, discontinues coverage of such children under such plan;

(B) the State provided for eligibility, under its plan under title XIX as of June 1, 1983, of individuals who are receiving, are eligible to receive, or could be eligible to receive (if coverage under its plan under title IV was as broad as allowed under Federal law) aid pursuant to the operation of section 407 (relating to dependent children of unemployed parents) or who are described in section 1905(a)(i) (but not in section 1902(a)(10)(A)(i)), and, after such date, discontinues or reduces the terms of eligibility of such individuals under such plan; or

(C) the State has made other significant reductions in eligibility or benefits under its plan under title XIX in order to establish or operate a plan under this part.

(3) Nothing in this section shall be construed as preventing a State from terminating its plan under this part and establishing a date after which the State is no longer obligated for expenses for medical benefits incurred under the plan.

(4) Sections 1116 and 1904 shall apply to plans approved under this part in the same manner as they apply to plans approved under title XIX, except that any reference to the provisions of section 1902 or 1904 in those sections shall be deemed for this purpose to be a reference to the provisions of this section or this paragraph, respectively.

(c) ELIGIBILITY FOR MEDICAL BENEFITS.—(1) Each State plan shall specify the criteria (consistent with this subsection) for determining those individuals who are eligible for medical benefits under the plan, which criteria shall be applied uniformly. Each individual who meets such criteria shall be eligible to enroll for medical benefits under the plan.

(2) Except as provided in paragraphs (3) and (4), an individual may not bet eligible for medical benefits under a State plan unless the individual is unemployed and—

(A) is receiving unemployment compensation or received unemployment compensation for a week in the previous 104-week period, or

(B) subject to paragraph (5)—

(i) has been previously employed (as determined under the plan), and

(ii) meets such reasonable financial or medical needs standards as the State plan specifies.

The State plan shall provide for standards respecting the circumstances under which an individual is considered "employed" and "unemployed" for purposes of the plan and the State plan may not make, as a condition of eligibility of any individual under subparagraph (A), any determination respecting the income or assets of any individual.

(3)(A) Except as provided in paragraph (4), for any period in which an individual is entitled to medical benefits under the plan, the individual's immediate family members (as defined in section 2101 (b)(2)) also shall be entitled to medical benefits under the plan.

(B) In the case of an individual who is eligible and enrolled for medical benefits under a State plan, the plan may continue the individual's eligibility during a period (of not longer than four weeks) specified in the State plan during which the individual is reemployed.

(4)(A) Except as provided in subparagraph (B), the State plan shall specify the uniform minimum length of time an individual must have been previously unemployed in order to be eligible for medical benefits under paragraph (2)(A).

(B)(i) Subject to clause (ii), a State plan may provide for a minimum length of period of unemployment which is less than that specified in subparagraph (A), but only with respect to providing eligibility for pregnant women, children under five years of age at the time of initial eligibility under the plan, and, at the State's option, immediate family members of such individuals.

(ii) A State plan may provide for a period under clause (i) of—

(I) less than one year (but greater than six months), only if the period described in subparagraph (A) is no greater than one year, or

(II) less than six months, only if the period described in subparagraph (A) is no greater than six months.

(5) A State plan must be reasonably designed so as to provide an amount of medical benefits in any fiscal year to individuals made eligible under paragraph (2)(B) (and their immediate family members) which is not less than 5 percent of the amount of the Federal payments to the State under section 2102(d) for that year and is not greater than the sum of—

(A) 5 percent of the amount of the Federal payments to the State under section 2102(d) for that year, and

(B) the amount (if any) by which the total amount of the expenditures under the plan for the year exceeds the sum of (i) the amount of the Federal payments to the State under section 2102(d) for that year and (ii) the amount of premiums collected under the plan for the year.

(6) A State plan may not permit an individual to be eligible for medical benefits under paragraph (2) for a week if the individual—

(A) is covered (or could have been covered, if any election had been made and any premiums required paid on a timely basis) for the week under a group health plan for which a contribution towards the cost of the plan is being made by an employer, union, or entity other than the individual or the individual's spouse;

(B) is (or could be, if an enrollment after the date of the enactment of this part had been made and any premiums required paid on a timely basis after the individual became unemployed) covered for the week under a group health plan for the individual's spouse for which a contribution toward the cost of the plan is being made by an employer, union, or entity other than the individual or the individual's spouse; or

(C) is determined to be eligible for the week for assistance under the State plan under title XIX.

(7) If a State changes the criteria for eligibility of individuals under the plan, such changes must be made public and made in a manner consistent with the State administrative procedures act or other applicable State law. A State may provide that in the case of such a change that would have the effect of disqualifying individuals who are eligible and enrolled for medical benefits under the plan, the State may provide for continuation of eligibility of the individuals for a reasonable period of time or based on such reasonable standards as the State may establish, but not beyond the period of time which they would otherwise have remained eligible.

(8) The State plan may limit the coverage period of eligible individuals under the plan to a period specified in the plan, but such period may not be less than one year in the case of individuals eligible under paragraph (2)(A).

(9) A State plan must permit an eligible individual to terminate voluntarily enrollment under the plan by written notice to the State.

(d) Medical Benefits.—(1) A State plan must provide medical benefits for—

(A) prenatal, delivery, post-partum, and well-baby care, without limitations of amount, duration, or scope except as to medical necessity;

(B) at least the first day of inpatient hospital care in the coverage period for each eligible individual; and

(C) at least some ambulatory services.

(2) The scope, amount, and duration of medical benefits provided under the plan must be the same for all individuals eligible for medical benefits under the plan, except that the coverage period of individuals eligible under subsection (c)(2)(A) may differ from the coverage period for individuals eligible under subsection (c)(2)(B).

(3) A State plan may not provide for medical benefits for expenses incurred for services furnished before the date the plan first becomes effective or after October 1, 1985.

(e) Premiums and Copayments.—(1)(A) A State plan may impose a weekly premium for an individual who is eligible under subsection (c)(2)(A), is receiving unemployment compensation, and is voluntarily enrolled in the plan in an amount equal to not more than 5 percent of the amount of the unemployment compensation, if any, which is payable to the enrollee for the week (determined without regard to any deductions or offsets actually taken thereon). The State

may provide for the deduction of the amount of such a premium from the amount of such compensation paid to the enrollee.

(B) A State plan may impose a premium for an individual who is eligbile under subsection (c)(2)(A), is not receiving unemployment compensation, and is voluntarily enrolled in the plan in an amount equal to not more than 2 percent (or, if less, the percentage applicable under subparagraph (A) to individuals described in that paragraph) of the average monthly benefit amount in the State for unemployment compensation under State law (based on the most recent data available).

(C) A State plan may not impose any premium, enrollment fee, or similar charge except as provided in this paragraph. If a State plan imposes a premium upon the enrollment of an eligible individual under the plan, the plan may not deem or otherwise treat the individual as being enrolled without the individual voluntarily enrolling under the plan.

(D)(i) Except as provided under clause (ii), the applicable percentage selected under subparagraph (A) or subparagraph (B) shall be uniform within the groups of individuals described in each of such subparagraphs.

(ii) A State plan may provide standards whereby the premiums otherwise established under the plan are waived in the case of financial hardship or other good cause established by the State.

(E) Premiums collected under a State plan must be used for the purpose of carrying out the plan and may be used, to the extent permitted under subsection (f)(4)(B), toward the State contribution for expenditures under the plan.

(2)(A) A State plan under this part shall provide for the imposition, to the extent permitted under paragraphs (2) and (3) of section 1916 with respect to individuals eligible for medical assistance under State plans under title XIX, of—

(i) a deductible, for the first day of inpatient hospital services furnished to an individual under the plan under this part, in an amount equal to at least 10 percent of the estimated average payment in the previous year for a day of inpatient hospital services under the State's plan under title XIX, and

(ii) deductions, cost sharing, and similar charges for other services in the maximum amounts permitted pursuant to such paragraphs for such individuals for such services.

(B)(i) Except as provided under clause (ii), the deductions, cost sharing, and any similar charges imposed under this paragraph shall be imposed uniformly for all individuals eligible for medical benefits under the plan.

(ii) A State plan may provide standards whereby the deductions, cost sharing, and any similar charges imposed under this paragraph are waived in the case of financial hardship or other good cause established by the State.

(f) STATE CONTRIBUTIONS.—(1) The State plan must provide for a State contribution towards expenditures under the plan in accordance with this subsection.

(2) With respect to expenditures under the plan for which amounts may be paid from allotments for 1983, the State is not required to make any State contribution.

(3) With respect to expenditures under the plan for which amounts may be paid from allotments for fiscal year 1984 or 1985, if the State has a State unemployment rate for the fiscal year equal to—

(A) 10 percent or more and such rate is—

(i) equal to or greater than 133⅓ percent of the national average total unemployment rate for that year, the State is not required to make any State contribution, or

(ii) less than 133⅓ percent of the national average total unemployment rate for that year, the State's contribution must be equal to at least 5 percent of the sum of the minimum State contribution computed under this clause and the amount of the Federal allotment paid the State under this part for that year;

(B) less than 10 percent, but more than 6 percent, the State's contribution must be equal to at least a percentage of the sum of the minimum State contribution computed under this subparagraph and the amount of the Federal allotment paid to the State under this part for that year, such percentage equal to 20 percent minus the product of 15 per centum and the ratio of (i) the percent difference between the State unemployment rate for that year and 6 percent, to (ii) 4 percent; or

(C) 6 percent or less, the State's contribution must be equal to at least 20 percent of the sum of the minimum State contribution computed under this subparagraph and the amount of the Federal allotment paid to the State under this part for that year.

As used in this paragraph, the term "State unemployment rate" means for a fiscal year for a State the average of the monthly civilian labor force unemployment rates in that State (as determined and published on a non-preliminary basis by the Bureau of Labor Statistics) for the most recent three-month period for which data are available before the beginning of the fiscal year.

(4)(A) Except as provided in subparagraph (B), the State plan must provide for financial participation by the State in an amount not less than the State contribution required under this subsection.

(B) A State may use premiums collected under the plan towards its State contribution required under this subsection, but such premiums may not be used to offset more than 50 percent of the State's required contribution with respect to any fiscal year.

(g) Administration of Plan.—(1) The State plan must provide that not more than 10 percent of the expenditures under the plan for any fiscal year are for expenses for administering the plan, except that this restriction shall not apply to 10 percent of the allotment to the State for fiscal year 1983.

(2) A State may elect to provide for the administration of part or all of its plan under this part by the single State agency (and in accordance with its plan approved) under title XIX. In such case, the State shall provide the Secretary with such information as may be reasonably necessary to identify or otherwise compute the costs of administration under title XIX which are attributable to the administration of this part and which are to be reimbursed from amounts paid the State under this part.

(3) If the State plan provides for any administrative functions under the plan to be performed by or through the State agency administering the State's unemployment compensation law, the State plan

must make appropriate arrangements to reimburse such agency (and, to the extent the Railroad Retirement Board performs similar functions pursuant to section 2105(c), to make appropriate and similar arrangements to reimburse the Board) for its reasonable expenses of performing such functions under the plan.

ALTERNATIVE STATE ARRANGEMENTS

SEC. 2104. (a) (1) A State plan under this part may provide an enrollee with the voluntary option of electing to receive medical benefits through an arrangement with a health benefits plan (including a private insurer, prepaid health plan, provider, or a provider group), rather than in accordance with section 2103, if—

(A) the scope, amount, and duration of benefits made available under the arrangement are at least equal to the scope, amount, and duration of benefits otherwise provided under the plan;

(B) with respect to services covered under the State plan, any premiums and charges provided under the arrangement do not exceed the premiums and charges permitted under section 2103 (e); and

(C) under the arrangement, the amount of payment under the plan may not exceed the actuarial value of payments for medical benefits which the State reasonably estimates would otherwise have been made under the plan.

(2) The State may provide that an enrollee who has exercised an election under this subsection may not terminate or modify such an election (other than for cause) for a period of up to 6 months beginning with the first month in which the election takes effect.

(b) (1) A State plan under this part may provide an eligible individual enrolled with the State under this part with the voluntary option of electing, in lieu of otherwise receiving medical benefits under the plan, of having the State make a cash payment (in the amount determined under paragraph (2) (A)) towards the premium or similar charge of enrolling the individual (and immediate family members) in a health insurance or benefits plan described in paragraph (3).

(2) In the case of an individual making an election under this subsection——

(A) the amount of the cash payment by the State towards the cost of the plan shall not exceed the actuarial value of payments for medical benefits which the State reasonably estimates would otherwise have been made under the plan, and

(B) the State plan may provide that the individual may not terminate or modify such an election (other than for cause) for a period of up to 6 months beginning with the first month in which the election takes effect.

(3) A health insurance or benefits plan (including a private insurer, prepaid health plan, provider, or a provider group), in order to be eligible under a State plan under this subsection must make an arrangement suitable to the State under which it provides to each individual, before the individual is enrolled with the plan under this subsection, a written description of the benefits, charges, and costs under the plan. The benefits provided under such a plan and the premiums and other charges imposed under the plan need not comply with the provisions of subsections (d) and (e) of section 2103.

(c) A State plan may provide for an arrangement with one or more private health benefits plans under which health insurance or health benefits are made available in accordance with the plan and section 2103 for all individuals in the State eligible under the plan.

REPORTS, AUDITS, AND MISCELLANEOUS PROVISIONS

SEC. 2105. (a) Each State shall prepare and submit not later than February 1, 1985, to the Secretary and each House of Congress (in such form and manner as the Secretary determines, after consultation with the States and the Comptroller General, to be appropriate) a report on its activities through fiscal year 1984 under its plan. Such report shall include, among other items, a description of—

(1) the criteria for eligibility of individuals under the plan and the number of individuals enrolled for benefits through the period under the plan, and

(2) the medical benefits made available under the plan, the total amount of expenditures made under the plan through the period, the portion of such expenditures spent on inpatient and ambulatory services, and amount of expenditures under the plan per enrollee through the period.

(b)(1) The provisions of sections 506 (other than subsection (a)) and 508 of this Act (relating to audits and access to information and nondiscrimination under the maternal and child health services block grant) shall apply to expenditures and activities under this part in the same manner as those provisions apply to expenditures and activities under title V; and for this purpose any reference to that title in any of those sections shall be deemed a reference to this part.

(2) The provisions of section 1909 shall apply to State plans under this part in the same manner as they apply to State plans under title XIX.

(3) A waiver granted a State under section 1115 or 1915(b), as such waiver applies to the requirements of a State plan approved under title XIX, shall be considered to be approved as a waiver of the corresponding requirements of this part.

(4) A State plan approved under this part shall be treated as a State plan approved under title XIX for purposes of applying section 1307(d) of the Public Health Service Act.

(5) The provisions of section 1128A shall apply to payments made from an allotment to a State under this part in the same manner as they apply to payments made from an allotment to a State under title V, and any reference to a State agency under such section shall be deemed for this purpose to be a reference to any agency or entity administering part or all of the State plan under this part.

(c)(1) If, in a State, the State agency administering the State's unemployment compensation law is responsible for collection of weekly premiums under section 2103(e) with respect to individuals receiving unemployment compensation under that law, the Railroad Retirement Board shall be responsible for the collection of weekly premiums under such section with respect to individuals receiving unemployment compensation under the Railroad Unemployment Insurance Act and residing in that State.

(2) In the case of other functions which a State agency administering the State's unemployment compensation law is required to perform under the State plan with respect to individuals receiving un-

employment compensation under that law, the Railroad Retirement Board shall, to the extent feasible, perform such functions with respect to individuals receiving unemployment compensation under the Railroad Unemployment Insurance Act and residing in that State.

(d) The Secretary may not delegate to the States his authority under this part to establish standards for the approval of State plans, to determine the acceptability of such plans, or to make other determinations required to be made by the Secretary under this part (including the specification of information to be contained in the report described in subsection (a)).

Part B—Open Enrollment, Continuation, and Conversion Rights of Individuals

requirements for employee health benefits plans

Sec. 2121. (a) Any group health plan offered by a large employer (as defined in section 2125(1)(B)) to employees shall meet the requirements of sections 2122 and 2123 and, if applicable, section 2124.

(b) The Secretary, after consultation with the Secretary of the Treasury, shall promulgate such regulations as may be necessary to carry out this part.

(c)(1) The requirements of this part shall not be construed as preventing employers (under collective bargaining agreements or otherwise) from providing additional or other health care benefits respecting employees or former employees.

(2) The requirements of this part shall not apply to employees covered under collective-bargaining agreements entered into before the date of the enactment of this title during the period covered by such agreements (as in effect on such date).

(d)(1) For an excise tax on the expenses incurred by large employers for group health plans failing to meet the requirements of this part, see section 4912 of the Internal Revenue Code of 1954.

(2) For a requirement that the group health plans of each State, and political subdivisions thereof, comply with the requirements of this part as a condition of payment of block grants to the State under part A, see section 2102(d)(4).

requiring open enrollment for spouses of unemployed workers

Sec. 2122. (a) A group health plan meets the requirement of this section only if it provides for an open enrollment period of at least 30 days duration for each married employee who is (or at a previous time was) eligible to enroll or is enrolled under the plan and whose spouse loses coverage under a group health plan due to the involuntary layoff or involuntary separation (other than for cause) from the spouse's employment. For purposes of this preceding sentence, a spouse shall not be considered to have lost coverage during any period (after the involuntary layoff or separation from employment) in which such coverage is continued and for which a contribution toward the cost of the coverage is being made by an employer, union, or entity other than the spouse.

(b) The terms of an enrollment during a period provided under subsection (a) shall be the same as the terms (including any option for coverage of immediate family members) most recently offered with respect to the enrollment of that employee or (at the employer's

option) to newly hired or other employees similarly situated, except that such enrollment may not require or discriminate on the basis of lack of evidence of insurability and if the employee was previously covered and only exercises the option to cover immediate family members the coverage of such immediate family members shall begin on the date the option is exercised.

(c) The requirements of this section shall apply to individuals whose spouses lose coverage under a group health plan on or after January 1, 1984.

REQUIRING CONTINUATION OF GROUP HEALTH CARE COVERAGE FOR UNEMPLOYED WORKERS

SEC. 2123. (a) A group health plan meets the requirements of this section only if an employee covered under the plan who would otherwise lose such coverage as a result of the individual's involuntary layoff or involuntary separation (other than for cause) from employment, is provided continuation of such coverage under a group health plan meeting the requirements of subsection (b) for a period of not less than 90 days following the date of the individual's involuntary separation or layoff (except as provided in subsection (c)). If at the time of the individual's layoff or separation some or all of the individual's immediate family members also were covered under the group health plan, the health benefits coverage under this subparagraph also must cover such immediate family members, unless the individual elects otherwise.

(b) In the case of continuation of coverage of health care benefits under subsection (a) under a group health plan—

(1) the continued health care benefits must not be less, in amount, duration, or scope of benefits, than either the benefits provided under such group health plan or ten physician visits and nine days of inpatient hospital services in any calendar year, whichever particular benefits are less, and

(2) the employer must provide for a contribution toward the cost of such continued health care benefits for an individual (and immediate family members) which is not less, in proportion to the cost of such continued benefits, than the proportional contribution the employer makes toward the cost of the group health plan for employees in the same classification as the individual involved.

(c) Subsection (a) shall not be construed as requiring continuation of coverage with respect to a former employee after the date—

(1) the individual provides written notice to the employer of his intention not to accept or continue such coverage,

(2) the individual has been reemployed for a period of four consecutive weeks, or

(3) the individual has failed to provide for timely payments of any premiums required.

(d) For purposes of this section and section 2124, the term "employee" does not include a temporary employee (as defined by the Secretary).

(e) The requirements of this section shall apply to individuals who are involuntarily laid-off or separated from employment on or after January 1, 1985.

REQUIRING UNEMPLOYED WORKERS COVERED UNDER INSURED GROUP HEALTH PLANS TO HAVE THE RIGHT TO CONVERT TO INDIVIDUAL POLICIES

SEC. 2124. (a) An insured group health plan meets the requirement of this section only if an employee covered under the plan is permitted the option, during the period described in subsection (b), of securing health benefits coverage, without evidence of insurability of the individual or immediate family members, where the loss of coverage under the group health plan is the result of the individual's involuntary layoff or involuntary separation (other than for cause) from employment. If at the time of the individual's layoff or separation some or all of the individual's immediate family members also were covered under the group health plan, the individual must be given the option of securing health benefits coverage under this subsection that also covers immediate family members.

(b) The period referred to in subsection (a) for a former employee is the 31-day period beginning on the date of the individual's layoff or separation from employment, or, at the option of the individual, beginning on the last day of any continuation of health benefits coverage under the group health plan or under section 2123.

(c) The requirements of this section shall apply to individuals involuntarily laid-off or separated on or after January 1, 1985.

DEFINITIONS

SEC. 2125. As used in this part:

(1) (A) The term "employer" does not include the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision thereof, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing, except that such term includes nonappropriated fund instrumentalities of the Government of the United States.

(B) The term "large employer" means an employer who, on each of some 20 days during the calendar year or the preceding calendar year, each day being in a different calendar week, employed for some portion of the day (whether or not at the same moment of time) 25 or more individuals.

(2) The term "group health plan" has the meaning given such term in section 162(i)(2) of the Internal Revenue Code of 1954.

(3) The term "insured group health plan" means a group health plan under which an entity, which is subject to the insurance laws or regulations of a State or to the laws of a State respecting hospital, medical, or dental service corporations, assumes the financial risk for paying benefits under the plan in exchange for payment of premiums under the plan.

(4) The term "immediate family member" means, with respect to an individual—

(A) in the case of a married individual, the individual's spouse, and

(B) the individual's child, if the child is under 18 years of age.

PART C—ASSISTANCE TO HOSPITALS SERVING THE UNEMPLOYED

GRANTS

SEC. 2141. (a)(1) The Secretary shall make grants to hospitals meeting the requirements of subsection (b) to assist the hospitals in providing services to persons unable to pay for such services.

(2) In making such grants, the Secretary shall—

(A) first give priority to hospitals which are either (i) public hospitals (or hospitals operated by a public benefit corporation) or (ii) hospitals serving areas not served by a public hospital, and

(B) then give priority to other hospitals which demonstrate that they serve a significantly disproportionate number of patients who are unemployed and who are unable to pay for hospital services.

(b) A hospital is not eligible for a grant under this section unless the hospital—

(1)(A) is located in an area experiencing high unemployment (as determined by the Secretary), or (B) serves primarily medically underserved populations as defined in section 330(b)(3) of the Public Health Service Act);

(2) serves a significantly disproportionate number of patients who have low income and who are unable to pay for hospital services;

(3) provides services to persons without regard to their ability to pay;

(4) provides evidence, satisfactory to the Secretary, that if the hospital is required, pursuant to an assurance under title VI or XVI of the Public Health Service Act, to make available a reasonable volume of services to persons unable to pay therefor, the hospital has made (and is making) such a volume of services available for the period for which the assistance is sought; and

(5) offers assurances satisfactory to the Secretary that it will use the sums provided in the grant in addition to, rather than in lieu of, existing Federal, State, and local funds currently available for the purposes described in subsection (a).

(c)(1) No grant may be made under this section unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and contain such information as the Secretary shall prescribe.

(2) The amount of any grant under this section shall be determined by the Secretary.

(d) The Secretary shall report to the Congress not later than March 31, 1985, and March 31, 1986, on the identity and location of hospitals provided assistance under this section and an estimate of the change in the number of individuals who are unable to pay for services and who were provided services in each of such hospitals receiving such assistance compared to the number of such individuals in the previous period.

(e) For the purpose of making grants under this part, there are authorized to be appropriated——

(1) for fiscal year 1984, $96,000,000,

(2) for fiscal year 1985, $77,000,000, and

(3) for fiscal year 1986, $60,000,000.

INTERNAL REVENUE CODE OF 1954

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Subtitle D—Miscellaneous Excise Taxes

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Subchapter A—Public Charities

[CHAPTER 41—PUBLIC CHARITIES]

CHAPTER 41—PUBLIC CHARITIES; CERTAIN HEALTH PLANS OF LARGE EMPLOYERS

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Subchapter B—Health Plans of Large Employers Which Do Not Meet Coverage Requirements for the Unemployed

SEC. 4912. TAX ON EXPENSES OF HEALTH PLANS OF LARGE EMPLOYERS WHICH DO NOT MEET COVERAGE REQUIREMENTS FOR THE UNEMPLOYED.

(a) TAX IMPOSED.—In the case of a large employer, there is hereby imposed a tax equal to 10 percent of the amount of the nonqualified employee health expenses paid or incurred during the taxable year.

(b) LARGE EMPLOYER.—For purposes of this section, the term "large employer" has the meaning given to such term by section 2125 (1) of the Social Security Act (as in effect on the day after the date of the enactment of this section).

(c) NONQUALIFIED EMPLOYEE HEALTH EXPENSES.—For purposes of this section—

(1) IN GENERAL.—The term "nonqualified employee health expenses" means the expenses paid or incurred by the employer for a group health plan to the extent such expenses are allocable to a period during which such plan does not meet each requirement contained in part B of title XXI of the Social Security Act (as in

effect on the day after the date of the enactment of this section) which under such part such plan is required to meet.

(2) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given to such term by section 162(i)(2).

(d) TERMINATION.—Subsection (a) shall not apply to amounts paid or incurred after December 31, 1986.

(e) CROSS REFERENCES.—

(1) For provision denying deduction for tax imposed by this section see section 275(a)(6).

(2) For provisions making deficiency procedures applicable to tax imposed by this section, see section 6211 et seq.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter B—Miscellaneous Provisions

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SEC. 6104. PUBLICITY OF INFORMATION REQUIRED FROM CERTAIN EXEMPT ORGANIZATION AND CERTAIN TRUSTS.

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(a) INSPECTION OF APPLICATIONS FOR TAX EXEMPTION. * * *

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(c) PUBLICATION TO STATE OFFICIALS.—

(1) GENERAL RULE.—In the case of any organization which is described in section 501(c)(3) and exempt from taxation under section 501(a), or has applied under section 508(a) for recognition as an organization described in section 501(c)(3), the Secretary at such times and in such manner as he may by regulations prescribe shall—

(A) notify the appropriate State officer of a refusal to recognize such organization as an organization described in section 501(c)(3), or of the operation of such organization in a manner which does not meet, or no longer meets, the requirements of its exemption,

(B) notify the appropriate State officer of the mailing of a notice of deficiency of tax imposed under section 507 [or chapter 41 or 42] , *subchapter A of Chapter 41, or 42*, and

(C) at the request of such appropriate State officer, make available for inspection and copying such returns, filed statements, records, reports, and other information, relating to a determination under subparagraph (A) or (B) as are relevant to any determination under State law.

(2) APPROPRIATE STATE OFFICER.—For purposes of this subsection, the term "appropriate State officer" means the State attorney general, State tax officer, or any State official charged with overseeing organizations of the type described in section 501(c)(3).

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VII. DISSENTING VIEWS ON HEALTH INSURANCE FOR THE UNEMPLOYED

We oppose, both procedurally and substantively, our Committee's action on legislation regarding health insurance for the unemployed.

"Action" seems an appropriate, if highly generalized, word to describe what the Committee did. In effect, we ordered reported a "Committee Proposal" which has been described, colorfully but with cause, as "six pages of dreams." We understand the time constraints under which the Committee was forced to operate; our jurisdiction over the subject was coming rapidly to an end. But that does not, in our opinion, justify the kind of summary action given to this kind of watershed legislation.

The Committee's dcisions are designed to create an entire title—the twenty-first—of the Social Security Act. With funding modeled on Title XX, this new addition would be in three parts: a block grant program entitling states to spend up to $350 million this fiscal year and $2 billion in fiscal year 1984 on health services for unemployed persons; a set of tax penalties on employers who fail to provide certain changes in coverage offered to employees; and a discretionary grant program to hospitals which serve the uninsured and unemployed.

Our Committee spent weeks—sometimes months—in developing virtually every other title of the Social Security Act. On Title XXI, the Committee spent only hours. Bypassing subcommittees, the proposition was entertained briefly late one afternoon and was discussed, amended, and finally voted on the next afternoon.

The Committee proposal would, except for very nominal payments from recipients, allow first-dollar coverage of Medicaid services to the unemployed, regardless of their income or assets, thereby creating new and serious inequities in our health care financing programs.

Single parent families, the elderly, and the disabled have to meet stringent income and assets test to receive Medicaid services. The Committee rejected three times proposals to add such tests to this program. The aged and disabled under Medicare have to pay significant amounts in deductibles and copayments. An uninsured elderly person has to pay $113 ($132 effective July 1, 1983) a month to purchase Medicare hospital coverage. Disabled persons have to wait nearly two and one half years from the onset of disability before they get benefits under Medicare. No such requirements would be imposed upon beneficiaries of this program.

And what about those 10 million or so employed Americans, without insurance, who may be poorer than the unemployed? And what about those unemployed persons who qualify neither for Medicaid nor this program? Is their need any less than those who would be covered under the Committee's proposal? How can we justify this program in view of such inequities?

Advocates of this proposition claim it will not continue indefinitely, and that its costs will not soar. But we recall, all too vividly, that simi-

lar assurances were given about other programs under other titles of the Social Security Act. Medicare, or Title XVIII, was projected to be containable, as far as the actuarial eye could see, back in the 1960's. That program is now projected to be bankrupt before the end of this decade and its deficits are projected at from $300–$400 billion by 1995. The disability insurance program, to cite another example, was projected in its early stages to cost no more than $3 or $4 billion per year. It now runs about $20 billion annually. And so the analogies can go.

An inevitable question thus arises: Who are we trying to kid about health insurance for the unemployed; are those who support this proposition really serious when they say it will be short-lived and not very costly?

As the Committee action now stands, it's an entitlement with a "cap", a major authorization with no financing mechanism. We do not insist that any one particular method of paying for the program is better than another, but we do insist that some method is necessary, and that no method connotes irresponsibility.

The "Committee proposal" is a monetary shotgun, spraying cash pellets at those who might need help and at those who might not. In fact, the Committee had no idea when it approved this proposition exactly how its benefits would be distributed among the poor and the rich. It is anything but targeted, and at a time when deficits loom so large, we think that programs such as this should, at the least, be designed to help those who have the greatest need.

Barber B. Conable, Jr.
Bill Archer.
Philip M. Crane.
Jim Martin.
Bill Gradison.
Carroll A. Campbell, Jr.
John J. Duncan.
Guy Vander Jagt.
Bill Frenzel.
William M. Thomas.

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